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ABSTRACT

This report provides an overview of the development and evaluation of an experimental television series for adult viewers on health care. The series was produced by the Children's Television Workshop and aired in prime time during 1974-1975 by the Public Broadcasting Service. The report synthesizes results of complementary impact studies conducted by four independent research contractors: a study of voluntary viewing by Response Analysis Corporation; an induced viewing field experiment by National Opinion Research Center; four national surveys by Gallup Organization; and national audience estimates by A.C. Nielsen Company. Chapters one and two describe the development of the series, summative research plans and findings. Chapters three and four examine media strategy issues concerning public television and its audience, and findings of the behavioral outcomes related to 24 specific health topics covered in the series. Limitations of the evaluation process, implications of the research findings, and suggestions for studies are discussed in the last two chapters. A summary of this report appears as a separate ERIC document. (SC)

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Evaluation of the FEELING GOOD Television Series

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REPORTS OF "FEELING GOOD" SUMMATIVE RESEARCH

Keith W. Mielke and James W. Swinehart, Evaluation of the FEELING GOOD Television Series. New York: Children's Television Workshop, 1976.

An overview of series development and evaluation, including a synthesis of studies conducted by the four independent research contractors cited below.

Summary: Evaluation of the FEELING GOOD Television Series. New York: Children's Television Workshop, 1976.

A condensation of the detailed report described above.

Morris N. Cohen and Herbert I. Abelson, Impacts, Benefits, and Consequences of FEELING GOOD. Princeton, New Jersey: Response Analysis Corporation, 1976.

A study conducted in Boston, Dallas, Jacksonville (Fla.), and Seattle to assess effects of voluntary viewing. Using mail questionnaires, approximately 4,000 adults responded before, during, and after the test interval of November 20, 1974--May 21, 1975. Subgroups of a panel effects control group (not pretested) received either a mid-series or a post-series measure.

Michael J. Minor and Norman M. Bradburn, The Effects of Viewing FEELING GOOD: Results from a Field Experiment in a Low-Income Community. Chicago: National Opinion Research Center, 1976.

A field experiment with substantial low-income and minority representation (all female), conducted in Dallas, Texas, using personal and telephone interviews (N=400+). Random assignment to a group induced to view and be interviewed, a group induced only to be interviewed, or a group receiving no inducements; sub-categories added later were based on actual viewing experience. Interview waves before, during and after the test interval of November 20, 1974--May 14, 1975.

The National Audience for FEELING GOOD. Princeton, New Jersey: The Gallup Organization, 1975.

Four national surveys using personal interviews with independent samples of 1,500+ adults each. Surveys were conducted between December 1974 and June 1975. Assessed awareness of FEELING GOOD, sources of awareness, incidence of viewing, and incidence of selected health care practices.

Nielsen Television Index Report on FEELING GOOD. New York: A. C. Nielsen Company, 1976.

A brief summary of national audience ratings for FEELING GOOD from November 1974 through January 1975 (Season A), April through June 1975 (Season B), and July through September 1975 (Season B rerun). The estimates are based on the Nielsen national Audimeter sample of TV households and include both Average Audience and Total Audience figures.

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Evaluation of the FEELING GOOD Television Series

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1976

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FOREWORD

by Edward L. Palmer
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The Concept

The experimental television series, Feeling Good, was conceived as an ambitious attempt to use television in innovative ways to influence preventive health behavior. It made its debut on the Public Broadcasting Service (PBS) in the fall of 1974. Six weeks later, Children's Television Workshop, creators of the series, announced that it would be taken off the air for eight weeks of extensive revisions. It was an expensive series, and the Workshop's expectations for it were correspondingly high. As the Workshop's president, Joan Ganz Cooney, pointed out at the time, the decision to take it off the air was initiated by CTW alone. Only the earliest Nielsen audience ratings were available, without any data whatsoever concerning impact on health information or health behaviors. The series was reaching about as many people as the top one-third of adult programs appearing on the public network. It was taken off the air because we simply believed it was not the best the Workshop could produce, either in terms of entertainment or as health education.

The shows produced beyond the pilot did not appear to be improving as well as we had anticipated. Moreover, audience ratings showed no sign that viewership was building, as it characteristically does for series that ultimately prove successful. The only way we saw possible to introduce a number of changes we felt were important was to introduce an eight-week mid-season hiatus.

Before discussing the actual changes made between Season A (the first eleven hour-long shows) and Season B (the 13 half-hour shows that followed), it may be useful to set down the rationale for each of several basic decisions that helped initially to define Feeling Good and its objectives. The project was designed as both an experiment in health education and an experiment in the uses of television. From the beginning we rejected conventional approaches in an attempt to explore new ways of using media to influence health behavior, an area in which previous efforts had not been notably successful. The Workshop proposed to create a prime-time series which would compete with commercial television programming to reach a mass television audience and motivate high-need viewers to adopt sound preventive health practices.

It was planned originally as 26 weekly, hour-long programs. There were deliberate reasons for producing 26 programs, for airing them weekly, and for making each an hour long. For one, an extended weekly series was seen to have a good chance to build a regular, loyal audience. For another, one original and one repeat showing of 26 weekly programs would fill out the calendar year, so that a continuing presence, critically important for audience loyalty, could be achieved. Twenty-six weeks also would permit experimentation with a greater number of health topics and production approaches than would a briefer series. A very significant consideration was the central intention of bringing real health benefits to the viewing public. In this regard, it was felt that only an extended series which provided a continuing presence and permitted repeated treatment of topics over a long period of time could hope to have an effect on anyone's day-to-day health habits. An alternative but obviously impractical approach would have been to orient the series more toward pure experimentation, and accordingly, to have presented fewer programs initially, followed by thorough evaluation before producing more. Unfortunately, this more experimental approach would have been prohibitively expensive. Costs for the same number of programs would have escalated markedly, because of the need to frequently start and stop work in the studio, and to prolong the period of staff employment.

The programs in the first half season were 60 minutes in length, and those in the second half, 30 minutes. The hour's length was important in the first half season, where the combination of entertainment and purposive fare made for a comparatively sparse amount of serious content. The hour simply provided more time to cover more topics. The hour also was thought to do more to dignify the subject and underscore its significance than the half hour, an important consideration in terms of promotability. It also lent itself better than the half hour to treatment of multiple topics within each program. The half-hour length, on the other hand, required a smaller weekly time commitment on the part of potentially loyal viewers.

The subject matter of the original series was to focus on health-related actions individuals could take for themselves, or on behalf of their families or friends. Moreover, the content was to deal with health maintenance and the prevention of sickness, and not with treatment and cure. The rationale for this emphasis was (1) recognition of the need for individuals to take on more responsibility for their own health maintenance; (2) neglect of health education in light of the almost exclusively "crisis and cure" orientation within the medical profession; and (3) the potential of reducing some of the enormous costs incurred each year in this country for curing problems that could have been avoided in the first place. Another major consideration in the selection of orientation for the series was the fact that most people already know a great deal more about healthful living than they actually put into practice. Thus the series was to be predominantly motivational, oriented toward narrowing the gap between knowledge and actual behavior. New information was presented for the most part only when it was felt to be instrumental to this purpose.

The audience for the series was conceived of originally as adults across all ethnic and socioeconomic groups, with particular emphasis on the needs and concerns of young parents and low-income families. A major objective set for the series, entirely apart from the promotion of good health, was to attract a greater audience than normally tunes in to prime-time PBS programming and to attract viewers who do not normally watch public television at all. This was always intended to mean a larger audience at all socioeconomic levels, including, but not exclusively, viewers from lower-income circumstances. In actual implementation, proportionately more time and effort went into planning material for the lower-income than for the upper-income portion of the audience, simply because their needs were seen to be greater and corrective action more difficult to achieve.

The formats for the series were to be predominantly those of popular television entertainment. Underlying the choice of this approach was the assumption that traditional information formats would tend to attract both a smaller and a disproportionately "up-scale" (higher socioeconomic) audience. Another underlying assumption was that more traditional informational approaches would tend to attract only those already concerned about their health. Still another was that popular television provides a rich variety of potentially motivating vehicles: characters with whom people can identify, attention-focusing and emotion-arousing dramatizations, and self-illuminating spoofs and parodies. Incidentally, "entertainment" always was construed in the broadest meaning of the term, and was never restricted to imply amusement alone. It was thought that a blues singer, or a dramatic and touching documentary, for instance, could be highly entertaining without being at all amusing.

Finally, it was assumed that for the series to compete with popular prime-time commercial programs, it would have to offer entertainment as well as serious health content. Entertainment, however, was seen to hold out not only the greatest opportunity to attract and motivate the audience, but also the greatest risk. From the beginning, it was clear that some entertainment forms and some items of serious health content would combine well while others would combine poorly. The key production problem was to develop the most effective blend of information and entertainment techniques to attract, entertain, and motivate a broad audience.

All the above issues and assumptions, and others as well, were reviewed by staff and advisors at the time of the decision to interrupt and revise the series. We had to ask if any extended, weekly hour-long series on health (or on any topic where the goal is to motivate the viewer to take self-help actions), presented in prime time on PBS could be successful. Even with the criterion for "success" limited for the moment to the ability of the series to attract large numbers of viewers, a considerable number of attributes had to be questioned and reviewed: the length of each show; the length of the entire series; the weekly frequency; the basic level of audience interest in the topic of health; the goal of motivating self-help actions; and the choice of a predominantly popular entertainment style.

Several elements were changed substantially for the second half season. Program length was reduced from an hour to half an hour, in hopes of encouraging regular weekly viewing. The program's "home base" and regular cast of characters, built around a variety store called Mac's Place, were replaced by a single host, the already well-known television personality, Dick Cavett. The host, unlike the earlier cast, could address the audience directly, commenting on upcoming or just completed segments, underscoring or elaborating upon key points, and attempting to motivate specific actions.

The subject-matter emphasis also was changed. One step was to emphasize topics inherently more interesting or potentially easier to treat because of their dramatic form or perceived consequences. Thus, such non-dramatic topics as nutrition, exercise, and dental care tended to be subordinated to cancer, heart disease, and alcoholism. There was less emphasis on lifestyle, and more on large and important but comparatively discrete topics. Also, partly for purposes of promotion, and partly to allow greater depth of treatment, each show was designed to address a single topic, rather than several, as in the first half season. For the most part, the emphasis on prevention as opposed to cure was retained.

Special attention was given to the complex issue of tone -- the perceived attitude of the presenters toward the audience. The hypothesis that certain pitfalls would have to be avoided in combining light with serious fare had been borne out in the formative (prebroadcast) testing of experimental segments. Attempted combinations within some segments had been seen as condescending. As expressed by test viewers, they were "too childish" or "too sugar-coated." Others had shown up among the most liked. At the same time, interestingly enough, one of the two most-liked segments from among the early test segments was a serious documentary on the work of an allied health professional trained to function in the capacity of Child Health Associate.

Condescension was not the only potential pitfall in the use of the combined approach. There was also the possibility that the entertainment and the serious health messages could simply get in the way of each other. Moreover, segments or programs combining the two might violate people's established expectations to be either entertained, or informed, but not both at the same time. There was also a need for sensitivity in order to avoid approaches which would arouse guilt or frustration among viewers, or admonish them to the point of being punitive. This was more likely to present a problem with the approach taken on Feeling Good, where the intention was primarily to motivate people to act on information already known, than it would have been with the alternative approach of offering mainly new information to be acted upon.

The series' deliberate attempt initially to focus on lifestyle -- on what people can do day by day and hour by hour to maintain and improve their health -- also doubtlessly had some effect on tone, particularly in the first half season. No matter how enthusiastic a producer may have felt about the importance of cultivating a lifestyle of preventive health maintenance, it could prove very difficult to find an interesting and compelling way to present some of the highly specific elements that make up that type of lifestyle. Examples are particular ways to avoid cholesterol, particular vegetables to select for high vitamin A content, the many conditions involved in household safety, and the myriad of symptoms pertaining to cancer, stress, alcoholism, and the like, to mention only a few.

The question could be asked whether the alterations performed on the series after the mid-season hiatus could not have been performed after the production of the pilot and before launching into the full series. In point of fact, some of the problems which led to the decision to interrupt the series already had shown up by then. However, the pilot was generally well-received in the testing and some corrections and modifications were planned at that time to strengthen the show. The hour's length had been questioned, but not seriously enough to warrant a last-minute cut-back to 30 minutes. The problem of condescension had been raised very clearly by the pilot testing, but it was felt that it could be overcome by judicious design of new materials and by emulating the approaches which were found to be most successful. We all felt that Mac's Place was not working as well as we would have liked. It was retained in Season A because the producers felt it could be made to work, with certain modifications, but also because in any case, there was not enough time to replace it in the short period between the production of the pilot and the onset of full series production. It held promise as a vehicle for true-to-life dramatizations, and it had performed reasonably well in the formative testing. More troublesome, but still not seen as intractable, had been the tendency for people from the middle and upper socioeconomic strata to judge the series as "Very interesting, but not, of course, for people like me."

The expectation that the programs in the full series would exceed the pilot in audience appeal was not borne out. In the formative testing, the pilot program, which later with modifications became the third program in the series tested out clearly higher in audience appeal than other early programs. This decline in program appeal resulted in large measure from the pressures of the production schedule, but it was exacerbated, we now believe, by the need for additional funding to bring more key members of the production staff into the project in its earlier stages (even though final series funding was not assured at the time). The problems of definition and of producing programs in the series' innovative genre simply were underestimated.

The upshot is that the first half season of Feeling Good, considered on a segment-by-segment basis, was neither a uniform success nor a uniform failure. Some elements worked well, and others did not. The proportion of successful elements simply was not sufficient to ensure its overall success. The series had attempted not merely to present health in engaging and entertaining ways, but to heighten the entertainment to a level competitive with commercial entertainment television. The expense of entertainment TV formats and techniques was borne in the hope of attracting a larger audience than could be attracted with use of more traditional information forms. In addition, it was thought that the expensive entertainment techniques of commercial television would be found particularly appealing to those in high-need categories (i.e., those who for whatever reason were not already keenly interested in preventive health), and those of lower socioeconomic status who were less likely to be already loyal viewers of PBS programming.

We ourselves have tried to weigh the costs of the series against its benefits. In sheer terms of audience numbers, it attracted enough viewers to place it above average among prime-time PBS programs. It also produced a number of significant, measurable effects (as presented elsewhere in this report), both in the first and in the second half seasons. The value of these effects is difficult to assess. It is made all the more difficult by the fact that not all the effects of the programs were (nor, practically speaking, could have been) measured. Nor were impact measures taken at all on some programs of the second half season, or on the extensive program of community outreach activities carried out by CTW and other cooperating organizations.

Certainly these effects, and all the lessons learned, in the aggregate, come to a considerable value. However, we now seriously question whether any weekly, hour-long, extended series on preventive health, presented in expensive entertainment formats in prime time on public television could achieve a combined reach and impact great enough to justify the magnitude of the investment. Even Season B, a weekly half-hour series on health topics which we considered inherently more appealing to all major audience groups, did not warrant continuation in light of its very substantial costs. We feel, however, that this outcome should not be taken to rule out the possible effectiveness of other patterns, such as a less expensive daily or weekly series; series of "spot" announcements, or series of five-, ten-, or fifteen-minute duration; a monthly series; occasional specials; a non-prime-time series; a series for commercial television; an extended series dealing non-exclusively with health; or extended series on other topic areas.

The Summative Evaluation

Because summative evaluation is the particular subject of this report, it is fitting that some of the project's technical achievements in that area be highlighted here. This is not a summary of results -- they are presented in the body of the report itself -- but a review of some practical approaches to the evaluation of broadcast television series.

First, it is noteworthy that measurable behavioral changes were detected. In spite of the fact that the nature of the Season B revisions ruled out repeated exposure to the series' motivational health messages, and in spite of the fact that the content of specific programs was often decided so late that it could not be reflected very precisely in the pretest instruments, the evaluation studies detected a number of statistically significant behavioral effects.

One of the project's examples for evaluations of future broadcast television series is that of undertaking complementary studies. For the five different studies undertaken in the evaluation of Feeling Good, this report rates each for its strengths and weaknesses on each of fifteen different criteria. In combination, the different designs satisfy all the criteria to some degree, and some key criteria particularly well. This approach is consistent with the philosophy of evaluation which holds that no single design can yield a comprehensive picture of the impact of most large-scale, complex experiments. Rather, that picture may emerge in mosaic fashion from a number of smaller studies, each highlighting different aspects of effect.

Another innovation grew out of the *a priori* expectation (based on the best of previous PBS experience) that fewer than one in twenty households would view the series, thereby making random-sample household surveys very inefficient. A method for identifying high-likelihood viewers of the series in advance, created by the Response Analysis Corporation (RAC), succeeded to a gratifying degree.

Another design innovation was created in response to the fact that it was not possible with either broadcast or cable television to establish a true experimental design, i.e., with viewing and non-viewing households, with random assignment to these two conditions, and with adequate representation of demographic subgroups. As a reasonably satisfactory alternative, in the RAC study, we called for comparisons of behavioral outcomes between individuals who viewed a particular program in the series and those who viewed one or more programs other than the particular one in question. In this fashion, it was possible to establish a control for so-called self-selection bias, the bias which could enter into a comparison of groups which by their own choice became either viewers or non-viewers. Without this innovation, the survey design in the RAC study could not have been employed because it would have been impossible to separate the effect of viewing from the effect due to a possibly greater interest in health on the part of the self-selected viewers.

Still another innovation grew out of the need to determine which program or programs in the series were viewed by a particular interviewee. Diaries were not feasible, because they tend to be reactive. That is, their very presence can affect the rate of viewing. Posttest recall over the entire series was not feasible, because memories grow dim. The solution was to take frequent interim measures, using different samples for each such measurement point, in order to reduce the problem of delayed recall, and to augment this procedure with questions about the content of specific programs.

Other lessons learned from Feeling Good are more general, and tend to deal with media issues. CTW at this time expects to seek additional funding to analyze and publish the results of the formative audience testing which was carried out originally for the in-house purpose of helping to guide production decisions. This work would be enormously useful in identifying the strengths and weaknesses of specific production approaches. More particularly, it would help us understand which entertainment techniques do and do not work well as vehicles for serious self-help messages, and perhaps also why they do or do not.

Our special gratitude is due to the members of the national Research Advisory Committee to the project. They are:

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Taken in combination, the four evaluation studies reviewed here are considerably larger in scale than any previous assessment of an adult public television series. Drs. Keith Mielke, Chairman of the Feeling Good Research Advisory Committee, and James Swinehart, the project's Director of Research, have done a splendid job, under often difficult circumstances, of designing the over-all set of complementary studies, monitoring their progress, and summarizing and presenting their findings, within the context of the project's original purposes. Their approach in this report reflects their mindfulness of the project's many significant implications for policy makers and practitioners in the fields of educational television, health education, and evaluation. Their open and frank discussions of problems and issues immeasurably enhance the value of this report.

CHAPTER ONE: DEVELOPMENT OF THE SERIES

Introduction

FEELING GOOD was an experimental television series on health, developed by the Children's Television Workshop (CTW), producers of SESAME STREET and THE ELECTRIC COMPANY. FEELING GOOD was the first CTW series designed for adults, and the first to be aired in prime time. This report brings together in summary form several assessments of its impact, drawing from separate reports* supplied by outside research contractors, and supplemented with contextual material from CTW on the development of the series and on the summative research program as a whole.

It should be noted at the outset that the FEELING GOOD programs changed significantly in mid-series. The original plan was for 26 one-hour programs to be broadcast weekly from November 20, 1974 through May 14, 1975. At the end of January, however, after 11 programs had been aired, FEELING GOOD was interrupted for eight weeks for a substantial revision. The new "second season," comprising 13 half-hour programs in a new format, ran from April 2 through June 25, 1975. For convenience, the convention is used of calling the first 11 programs "Season A" and the 13 half-hour programs "Season B". The repeat broadcasts of the half-hour programs during the summer (July 2 to September 24, 1975) are referred to as "Season B Rerun". The planning of the summative evaluation to assess series impact was an integral part of the preparation that led to Season A, and was initially based on Season A premises.

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*The source materials from outside research contractors are listed inside the front cover of this report. Neither this report nor the separate summative research reports covers an extensive in-house program of formative research, which provided information to the production staff before and during production.

The first chapter of this report describes the evolution of the series (through the changes of Season B); the second chapter covers development of the summative evaluation plan (again, through the changes of Season B); the third chapter reports findings concerning several issues involved in goal-oriented broadcasting; and the fourth presents findings on the effects of the series. Chapter Five concerns issues pertaining to evaluation of experiments like FEELING GOOD. Chapter Six reviews possibilities for additional research, and provides a discussion of several policy and media strategy questions not addressed directly by the evaluation studies.

Phase I: Preparation of the Proposal

FEELING GOOD was in preparation over two years. A small CTW Health Project staff initiated a feasibility study in June, 1972, which included visiting health care centers, interviewing 170 experts in various health fields, and critiquing selected film and television materials on health. In November 1972 these efforts culminated in a 126-page proposal to produce the series.

Decisions reported in this proposal provided significant premises for the series development; e.g., the upcoming series would

1) consist of 26 one-hour weekly programs;
2) be aired in prime time over Public Broadcasting Service (PBS) stations, typically with a daytime rebroadcast during the same week;
3) be produced in some version of a magazine format;
4) incorporate goals going beyond information gain and attitude change to specific behavioral changes;
5) address multiple topics and multiple target audiences within each program;
6) emphasize health needs of the poor, but strive for appeal to multiple groups in the general population;

7) attempt to combine entertainment and health information in ways that would attract audiences with low motivation to seek health information; and

8) continue the use of organizational features which were successful with previous CTW series, such as heavy use of promotion, an extensive community outreach program, in-house formative research, and the use of outside contractors for the summative evaluation of the series.

At the time initial planning for the series began, the nation's annual health care costs were approaching $100 billion and increasing rapidly. An estimated 92% of this amount was spent on treatment rather than on prevention of illness, and many studies indicated a need for more health education of the public: one out of three adults did not know any of the symptoms of cancer . . . half did not know their blood type . . . one-fourth did not know the symptoms of a heart attack. Medical authorities estimated that the incidence of heart disease could be reduced by half if available diagnostic techniques were fully used for early detection of heart problems, and that deaths from lung cancer could be cut by 60% if cigarette smoking were eliminated. There was evidence that heart ailments, cancer and venereal disease were on the increase despite the availability of means to reduce them. The infant death rate in the U.S. exceeded that of 14 other countries. Preventable communicable diseases killed 140,000 Americans a year. Health conditions were considerably worse for the poor than for others; two out of five had serious health problems caused by malnutrition, for example, and most were unable to obtain adequate medical or dental care.

Health experts consulted during the first phase of work for the series agreed that major social and environmental changes would be required to ameliorate many of the adverse influences on health. However, there was also agreement that individuals could do a great deal on their own behalf by taking appropriate preventive actions and adopting a healthier "lifestyle". One advisor stated what became the implicit theme of the series: "It's what you do, hour by hour, day by day, that largely determines the state of your health, whether you get sick, what you get sick with, and perhaps when you die."

Attempting to stimulate a shift from the traditional emphasis on treating illness to an emphasis on maintaining health was recognized as an extremely difficult task. Most commercial television series dealing with health had exploited the dramatic potential of medical crises. One of the major questions confronting the CTW series was whether programs stressing prevention rather than cure, and dealing with non-crisis topics, could attract an audience accustomed to seeing suspense-filled "doctor dramas" which reinforced the view that health problems are solved in hospitals. Experience with some earlier health programs on both public and commercial television offered a basis for believing that single programs could do so, but left open the question of whether a series could hold an audience on a sustained basis.

At the outset, the producers rejected conventional public affairs program formats for several reasons. Documentaries and interview programs were known to draw relatively small and select audiences; the producers hoped to attract a different and larger audience, and by doing so to broaden the reach of public television. Many previous programs on health had been designed only to explore an issue or to convey information; since FEELING GOOD was conceived as an attempt to do these things but also to influence behavior, the standard formats did not seem adequate. The producers also regarded the project as an experiment in television as well as in health education, and thus wanted to create a new format combining several approaches (drama, documentary, comedy, etc.) in each program. No one knew whether it could be done, or whether it would produce the desired results, but the standard formats had shown little success in attracting unmotivated viewers. In deciding to develop a new format incorporating entertainment, the producers traded the high probability of reaching a traditional audience for the possibility of reaching a larger and more appropriate audience--though they wanted to attract both.

Despite the hope offered by a new program format, the demonstrated need for a more informed public, and the potential health benefits of appropriate actions by individuals, there were many reasons for expecting that the series might have only modest impact. Public television was known to attract only a small proportion of adults, especially among the poor. It was recognized from previous experience with SESAME STREET that considerable time might be needed to achieve relatively high penetration into the low-income audience, and the competition of commercial programming in prime time made this problem even more difficult for FEELING GOOD. Treatment of several topics within each program meant that some elements of any particular show might be of little concern to many viewers (e.g., a segment on prenatal care would apply primarily to pregnant women, a small portion of the audience). There was a lack of consensus among experts as to what health information should be conveyed through open-circuit broadcasting. Many subjects of importance from a public health standpoint were known to hold little interest for the typical audience member, and the general theme of prevention lacked the appeal and motivating power of immediate life-threatening situations. Unless the usual patterns of audience self-selection were overcome, the people most likely to view would also be most likely to already know and do the things recommended; thus there might be relatively little opportunity to demonstrate change. The taking of recommended actions would be limited by such barriers as habits, personal or social values, cost, inconvenience, and fear of outcomes. Repeat viewership would have to be fairly high in order for repetition of messages on several programs to have a cumulative impact. The audience's exposure to advertising for such products as cigarettes, alcoholic beverages, and "junk foods" would be far greater than the most optimistic estimates of exposure for the series.

These difficulties were formidable, but there were grounds for believing that the series could achieve greater success than most previous efforts: more adequate preparation time, greater use of formative research, use of entertainment and guest stars to attract audiences, extensive promotion and outreach efforts, an emphasis on positive rather than negative appeals to motivate health behavior, and the visibility of a sustained weekly series of programs. The possibility that the series would produce useful new information and a measurable increase in preventive health behaviors was regarded as sufficient justification for further funding, and the project consequently continued to Phase II.

Phase II: Preparation for the Series

Phase II of the three-phase project began early in 1973 and extended through December of 1973. During this phase, preparatory work was done in the areas of content and goal development, exploration of various production formats, setting up formative research arrangements, planning promotion and community outreach programs, and holding initial discussions with outside consultants on summative evaluation strategy. Some of these preparatory steps are described briefly below.

During the year, CTW conducted nine Task Force meetings on the following topics:

1) adolescent health care problems
2) prenatal, infant, and child care
3) modification of personal habits
4) access to, use of, and participation in the health care delivery system
5) chronic diseases
6) family planning

7) death

8) mental health

9) nutrition

Nearly 100 health and medical professionals participated in these sessions. Each group discussed with CTW staff those topics that might be suitable for the series. The criteria for selection of topics, originally set out in the proposal for the series, proved to be a useful discussion guide:

1) The importance of the problem as defined by its prevalence and seriousness;

2) The degree of public interest in the subject;

3) The extent to which an individual can do something about the problem;

4) The extent to which a doctor or other health specialist can do something about the problem;

5) The potential for effective television treatment; and

6) The susceptibility to measurement of the impact of a program on the viewer's knowledge, attitudes, and actions.

Items 1 and 3 above were by far the most important in determining the topics finally chosen for treatment in the series. Some topics ranking high on these two dimensions were covered in spite of the fact that they ranked very low on others. A more conservative approach, commonly used in developing television programming, would have emphasized items 2 and 5.

CTW produced two hours of original material, designed to explore a wide range of production formats and techniques for conveying health information: e.g., music, drama, film documentary, skits, animation, comedy, and "commercials". These materials were edited into a sample reel approximately one hour in length for purposes of formative research testing. The formative research staff, which had been developing its techniques by testing existing programs (e.g., VD BLUES, I AM JOE'S HEART), tested the sample reel among various test audiences and reported its findings to the production staff.

The CTW staff continued to develop topics and goals for the series in consultation with Task Force members and other consultants. A Writer's Notebook, a synthesis of topic, goal, and audience information for the use of the creative staff, was also prepared.

Production of "Season A" in Phase III

Topics and Goals. Selection and refinement of topics and goals was an evolutionary process that continued throughout all three phases of the project. In the Phase I period of June-November, 1972, interviews with health specialists had identified more than 50 topics for potential series treatment. The Phase II Task Force meetings helped to narrow this list. In Phases II and III, the CTW Content Development staff, working with the research staff, prepared material on 11 priority topics, for which 70 behavioral goals were developed. These topics and goals were used extensively in series planning. The topics were:

1) alcohol abuse
2) cancer
3) child care
    a. immunization
    b. vision and hearing screening for preschoolers
    c. accident prevention in the home
    d. preparation for change
    e. language development
4) dental care
5) exercise
6) health care delivery system
    a. allied health personnel
    b. emergency medical services
    c. paying for care
    d. patients' rights
    e. doctor/patient communication
7) heart disease
8) high blood pressure (hypertension)

9) mental health

10) nutrition

11) prenatal care

(The pre-final list of potential topics also included venereal disease, sickle cell anemia, symptom recognition, common complaints, neighborhood care, consumer influence on health services, drug abuse, smoking, news of medical advances, and environmental health. These topics were all regarded as important, but were not included on the priority list because they were judged to rank below others in terms of various criteria.)

The behavioral and informational goals for the priority topics as treated in the series are presented in Chapter Four with the programming descriptions and evaluation results pertaining to them. The informational goals were intended to facilitate or support the behavioral goals, and in general were designed to increase perceptions of susceptibility to particular health problems, to emphasize the benefits of taking recommended actions, and to undermine barriers to taking these actions. Other appeals were also used as the programs developed.

The original 70 behavioral goals (some of which were not covered in the series as broadcast) were characterized as follows:

Purpose of action: health maintenance and/or prevention of illness or injury, 28 goals; detection or diagnosis, 21; treatment or control, 8; improved quality of care, 13.

Frequency of action: daily, 14; monthly, 1; annually, 2; once, 25; as appropriate or desired, 20.

Nature of interaction with health care providers: seeking care (diagnosis, treatment, advice), 21; seeking information or clarification, 6; no provider contact, 35.

Beneficiary of action: child, 23; self, 31; another adult, 9; community, 1.

Target audiences: all adults, 25; parents of preschool children, 15; all parents with children at home, 6; pregnant women, 5; health care providers, 7; women, 4; husbands, 3; adults over 40, 4; adults with high blood pressure, 3.

The following considerations were taken into account during the process of formulating goals for the series:

Importance of problem

> How important is this problem in relation to other health problems? (How many people does it affect? What kinds of people? Is it fatal, disabling, restricting, or only annoying? How costly are its consequences for society, family, individual?)

Efficacy of action recommended

> Are there actions which an individual can take to prevent or ameliorate the problem? How effective are these actions? Is there controversy regarding their effectiveness?

Feasibility of action recommended

> How likely is the individual to take the action recommended? If the action costs money, can he afford it? If it requires access to facilities, are the facilities available? Does he distrust or dislike the health care providers? Do people around him oppose taking the kinds of actions recommended? Would taking the action conflict with personal values or self-image? Are the actions recommended painful, boring, inconvenient? Does he think they will do any good? Does he think the problem could affect him? Are competing or reinforcing messages from other sources likely to be present?

Relation to other campaigns

> Is the problem one which has been or is being treated in a number of public education programs? If so, how effective have such programs been? How likely is it that we can produce TV material sufficiently different from, and more effective than, other material on this topic to justify treating the topic in the series? Are health agencies concerned with these problems more likely or

less likely than those concerned with other problems to cooperate with the series and thus increase its impact?

Measurability

What kinds of changes in knowledge and behavior regarding this topic are measurable in ways which will provide a valid indication of the series' effectiveness? How likely are the measures to be costly, require access to confidential records, involve a large field staff, or influence the outcome they are intended to assess?

Information points as appeals

If the problem affects one group (race, sex, etc.) more than another, should people be made aware of this? Is the topic one about which we should try to arouse fear or allay fear? If the problem is one people can do little about, should they be told this--or should they be told only about the things they can do? What points of information, individually or in combination, are most likely to lead people to take recommended actions?

Audiences

What kinds of people (e.g., mothers of young children, physicians or other health personnel, teenagers) are most affected by the problem? Are they also the ones in the best position to do something about it, or should the programs be addressed mostly to others? Have they tried unsuccessfully to do something about the problem? How much do they know about it? How many people have incorrect beliefs about its prevalence, seriousness, preventability, symptoms, or treatment? Are they afraid of it or apathetic about it? How great is the risk that, by emphasizing a point we view as important, we will actually decrease the number of people taking the recommended action? Are some information points or appeals likely to produce a negative reaction in some people while producing a positive reaction in others?

Although extensive efforts were made during the goal development process to obtain answers to these questions through searches of the literature and consultation with a number of health professionals, in many cases the answers were not available. In some areas (e.g., breast cancer, alcoholism, nutrition), recent studies had been done which provided a great deal of useful information; in other areas (e.g., prenatal care, accident prevention in the home, immunizations), decisions about program content were made without recourse to a data base regarded as adequate. If the findings obtained during the course of the summative evaluation of FEELING GOOD had been available at the time the goals were being developed, a number of information points might have been omitted because public awareness of them was found to be high. Many others in this category would still have been retained, however, since they were regarded as potentially useful or important for other reasons.

Target Audiences. Although special emphasis was placed on reaching young parents and low-income families, the nature and diversity of the topics chosen necessarily involved addressing multiple target audiences. Some goals were sex-specific, as with breast self-examinations for women. Other goals concerned age-specific audiences, as in seeking to motivate viewers over 40 to have a proctoscopic examination. Some goals had an ethnic emphasis, as in the area of hypertension (non-exclusive emphasis on black males) or vitamin A deficiency (primarily a Latino problem). Some topics involved only households with young children (e.g., preschool vision and hearing screenings), or pregnant women (e.g., prenatal care). Some topics were particularly relevant for low-income families. Several topics were symptom-specific (e.g., mental illness, alcoholism), and some were quite general (e.g., nutrition).

The complexity indicated above increases greatly when the target audience shifts from direct to indirect, as when a husband encourages his wife to get a Pap test, a friend is informed about allied health careers, or a family member learns to better cope with an alcoholic.

These examples illustrate the difficulty in stating simply and singularly what the target audience was, without also specifying the topic or goal involved. The difficulty of stratifying respondents on the degree of relevance of a particular topic or goal posed special problems for the summative evaluation, discussed further in Chapter Two.

Sequencing of Topics and Goals. Given an extensive and varied set of topics, goals, and target audiences, and given the Season A decision to cover multiple topics in each program, it was necessary to develop a strategy to determine when, how often, and how long any given goal should be treated in the series. In discussions with the production staff, a working premise was developed that a one-hour (58:30) program might typically contain

1) a "major treatment" of up to 20 minutes length on a single topic;
2) up to three "minor treatments" of five to ten minutes each on other topics;
3) three or four "commercials", each about a minute in length; and
4) up to 20 minutes of introduction, closing, and transitional or bridging material.

The following premises were then used to generate a proposed scheduling of topic/goal treatments in the proposed series:

1) No topic should get major treatment more than once in any month.
2) Major treatment should be given to only one topic in any single show.
3) The topics treated in any show should interest diverse audiences; that is, no show should be aimed entirely at a single segment of the total potential audience (e.g., persons responsible for children; persons interested in heart disease).
4) Whenever possible, the topics treated on a program should be compatible with one another. (It was recognized that this conflicted to some extent with #3 above.)
5) Each topic on the priority list should get major treatment at least once in the series and minor treatment several times in the series.
6) Minor treatment of some topics should be used within the month when major treatment is given to these topics (as a reinforcement of the message), particularly when a related campaign is being conducted by a national organization.

7) Such topics as "advances in medical care" (not on the priority list) should be dealt with in treating the priority topics rather than as separate entities.

8) Whenever appropriate, topics should be scheduled for major treatment at times when related campaigns are being conducted by other organizations.

9) Topics should be scheduled so as to be seasonally appropriate whenever possible.

10) In general, there should be no more than one behavioral goal for each topic treated in a show.

The proposed 26-program schedule of topics and goals that resulted from application of these premises then entered the decision-making process in production, where an even wider range of constraints had to be taken into account.

Development of the Series (Season A) Vehicle. While the Content and Research staffs were outlining the schedule of topics and goals, the Production staff was developing the program format and a mechanism for linking the varied kinds of segments (drama, comedy, documentary, etc.) to be used in each show.

The mechanism finally chosen involved the use of a shopping center setting and a multi-racial cast of characters who would work in or frequent the shopping center, particularly a dining counter/variety store called "Mac's Place". Such a setting had several desirable features. Viewer familiarity with shopping centers was almost universal. A wide variety of roles and personality types could be incorporated in a small cast. The setting offered possibilities for work-related situations, as well as explorations into the characters' personal lives. Repeated exposure to the various character roles offered opportunities for minority and other audiences to identify with a particular character. Development of a simple plot or story line in each program could be spaced in segments throughout the program, interspersed with substantive segments in any type of format. Interest in the unfolding story should provide a motivation to continue to watch the program even through segments where content was of minimal interest to a particular audience member.

Six characters were developed for regular appearances in the "Mac's Place" segments:

Mac: middle-aged white male, proprietor of the variety store;

Rita: mid-20's Puerto Rican woman, a waitress in Mac's Place and mother of a 5-year-old boy;

Melba: young black woman, operator of a health studio in the shopping center;

Jason: an intern at a nearby hospital, and Melba's husband;

Hank: middle-aged white male, owner of a sporting goods store;

Mrs. Stebbins: elderly white woman, a lonely grandmother and devoted reader of movie magazines.

The six characters above had multiple functions in the design of the program:

1) providing openings, transitions, and closings for the programs;

2) providing situation comedy entertainment;

3) conveying health information; and

4) providing opportunities for audience members to identify with someone like themselves.

The Pilot Program. After several weeks of production and editing, a pilot program was completed in July, 1974, and was submitted to extensive formative evaluations for in-house use. Reactions to the program were obtained from 1,910 adults in 13 cities across the country.

A description of the pilot program illustrates the "cluster concept" that was developed, wherein a single topic would be treated in several adjacent segments, each using a different production format:

1) "Mac's Place" opening scene. Nutrition cluster is set up.

2) Brief "man on the street" testimonials on good nutrition.

3) Satire of the eating scene from the movie Tom Jones, featuring leafy green vegetables.

4) Jody Miller song on green vegetables.

5) "Mac's Place" continuation. Immunization cluster is set up.

6) Bill Cosby monologue on children's immunizations.

7) Howard Cosell sports film segment on children's needs for "all the shots".

8) "Mac's Place" continuation. Hypertension segment is set up.

9) Satire on COLUMBO, a TV show; detective looks for a case of hypertension.

10) Bill Withers song on hypertension.

11) "Man on the street" comments on high blood pressure.

12) "Mac's Place" continuation. Breast cancer segment is set up.

13) Documentary on a family in which the mother has had breast cancer.

14) Song celebrating life.

15) Demonstration of the "clock test" method of breast self-examination.

16) "Mac's Place" continuation. Exercise cluster is set up.

17) Song on pleasures and benefits of walking.

18) "Commercial" on benefits to the heart from exercise.

19) "Mac's Place" closing scene.

The pilot program was altered in accordance with feedback from early audience testing and later appeared as the third program in Season A. By mid-September, 1974, the fall programs were in production.

Series Promotion. FEELING GOOD was extensively promoted in several ways by CTW's own Public Affairs Division with major assistance from the stations of the Public Broadcasting Service, and from many national and local organizations with an interest in public health education.

A brief, chronologic listing of the main promotional activities undertaken for the series, includes:

- Creation and distribution of a 100-page Communications Manual which included a catalogue of editorial, art and advertising elements to promote the series. Included were sample news releases and background statements, in English and Spanish, as well as reproduction sheets of flyers, posters and print ads, and a handbook giving instructions for developing and publishing a local Feeling Good Community Health Directory. The Feeling Good Communications Manual was distributed to the 250 PBS stations and to executive and public relations staffs of cooperating national groups such as the AFL-CIO and the American Cancer Society.

- A monthly newsletter, "The Feeling Good Report", was prepared and mailed to 20,000 health professionals, teachers, community leaders and media representatives during the pre-broadcast phase of the experiment.

- CTW staff members made numerous appearances at special briefings for Congressional staffs and national conventions of organizations such as the AAAS and the American Public Health Association.

- Posters announcing the series were sent to 300,000 doctors, dentists, hospitals, medical schools and high schools. These were posted in waiting rooms and on bulletin boards.

- One- and two-page four-color advertisements announcing the series were placed in several national magazines (Newsweek and Time, for example) by Exxon.

- National publicity about the premiere of the program was generated through newspapers, magazines, wire services, news syndicates, radio and TV feature programs. Throughout the series, each show was the subject of special feature and photo coverage which was aimed not only at general circulation media but at specialized publications for parents, senior citizens, educators, etc.

- A 30-minute special preview of the series aired on a selected list of commercial stations (and then repeated on the local PBS station) the weekend of November 16, with Exxon Corporation underwriting the cost. Exxon also placed spot announcements about the series within its regularly scheduled institutional advertising time on the "NBC Nightly News," and funded a special short featurette which was aired following an NBC weeknight movie.

- Tune-in ads were placed in major market daily newspapers across the country to promote the beginning of the original series of hour-long programs as well as the later series of 30-minute broadcasts. A new campaign of newspaper and magazine publicity was also conducted for the 30-minute episodes featuring Dick Cavett.

- On-air promos, featuring the topics for upcoming shows, were produced and distributed to PBS stations throughout Seasons A and B.

Community Education Services (CES). CES is the division within CTW initially established to provide promotion and utilization services in communities for the SESAME STREET series. CES has seven regional offices around the U.S., and these were engaged in community outreach efforts for FEELING GOOD in addition to their work on behalf of other CTW programs. For example, CES coordinators conducted meetings with health, education, and community groups; as a consequence, many state and local organizations were enlisted to assist in promoting the FEELING GOOD series and in follow-up activities. Some examples of CES activities for the series are given below.

- CES staff members contacted more than 1,500 national, state and local organizations between January 1974 and June 1975. These organizations reached over 3,500,000 people, many in poor and minority communities. These included welfare recipients, retired coal miners, food stamp recipients, county and neighborhood health clinic patients, public housing tenants, hospital workers, public school children, community action center clients, Headstart mothers, prison inmates, isolated Appalachian mountain families, Indian Reservation residents, senior citizens, Mexican Americans, Puerto Ricans and day care mothers.

- Special projects were developed to extend FEELING GOOD health information into the community. These included Feeling Good health fairs, screening drives for specific health problems, nutrition education projects, in-school health education classes, field training experience for college students, poster contests for school art classes, and alcohol education campaigns.

- In some cities, CES used the series to bring together community groups and resource agencies. For example, a nutrition education project was conducted at the Inkster (Michigan) Family and Neighborhood Services Agency in cooperation with a nutritionist from the local gas company. A seven-week course was developed for pregnant inner-city teenagers in an effort to get them to improve the nutritional balance in their diets, reduce high-in-salt snacks, and better control their weight. The FEELING GOOD shows were used to provide motivation and continuity.

- In some isolated regions of Appalachia, the home visitors of an educational cooperative took tape recorders into the homes of poor families and let them record personal questions they had about health topics after watching FEELING GOOD. These questions were answered on tape by participating doctors and nurses in the hospitals, and the answers were returned to the families on the home visitors' next visit.

- The CTW office in Jackson, Mississippi held a series of eight FEELING GOOD Health Fairs around the State of Mississippi. These fairs involved governmental health agencies, voluntary health organizations, colleges and universities, neighborhood health centers, and community organizations.

- In CES's Southwestern Regional Office in Texas, the Heart Association, The Dallas Museum of Health and Science, and health education students from Texas Women's University screened 3,500 black and Hispanic residents of South Dallas for hypertension.

- CES staff assisted stations in identifying local agencies and organizations from which viewers could obtain additional information about topics treated in the series. Each program included at least one "referral spot" with the name and address or telephone number of an agency which would handle inquiries. Most of the referral spots in the national programs mentioned the National Health Council as a general source, but the PBS stations were urged to replace this listing with the names and numbers of local organizations which could provide the same information. (A check of stations after the third program in Season A indicated that about 80% were doing so.)

The Station Experiments. In addition to the CTW staff members regularly assigned to communications and coordination with the PBS stations, two persons were employed to coordinate special efforts by eight PBS stations in local promotion and follow-up activities. Funds for these efforts were provided to CTW by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and were supplemented locally.

A CTW document describes the station experiments as follows: "The goal of the experiments was to determine various methods by which local stations could build community involvement around a national television effort. The experiments were designed to explore the use of local programming that would complement FEELING GOOD; gaining access and getting information to designated SES groups; developing resource centers for counseling and referral information; linking audio/phone library systems to station referral efforts; providing FEELING GOOD topics to hospitals and clinics as a way to reach specific target groups; using FEELING GOOD cassettes and setting up viewing rooms in designated lower-SES areas; and establishing a FEELING GOOD Theme Station."

The stations participating in this project were:

WJCT, Jacksonville, Florida
KCTS, Seattle, Washington
WCET, Cincinnati, Ohio
WMAA, Jackson, Mississippi
WPSX, University Park, Pennsylvania
WNED, Buffalo, New York
Maine Public Broadcasting
KQED, San Francisco, California

Following are some examples of activities conducted by these stations in connection with the series:

- producing local follow-up programs for broadcast immediately after FEELING GOOD on such topics as minority health problems, children's health, and local health resources
- participating in health fairs in shopping centers and elsewhere
- operating local referral services to arrange contacts between program viewers and various health agencies

- showing the programs on videocassettes to groups of people in small communities
- soliciting support from various sources to provide paid advertising for the series
- preparing and distributing copies of the FEELING GOOD Community Health Handbook, a listing of agencies and telephone numbers individually tailored for each community
- soliciting cooperation in promoting the series from state and local agencies, such as health departments and voluntary health organizations
- providing cassettes of FEELING GOOD programs for use with patients via closed-circuit television systems in hospitals
- cooperating with a Tel-Med service which provides taped health information in response to telephone inquiries
- producing and broadcasting spots promoting FEELING GOOD or specific health actions dealt with in the series
- arranging previews of FEELING GOOD programs for groups of health professionals
- promoting the series in a variety of ways, such as articles in newspapers and organizational newsletters, flyers mailed by welfare agencies and other organizations, and special notices to teachers regarding topics to be treated on future programs.

The Change to Season B

FEELING GOOD premiered on Wednesday evening, November 20, 1974, at 8:00 p.m. (EST), in competition with regular series on two commercial networks (LITTLE HOUSE ON THE PRAIRIE and THAT'S MY MAMA) and a special on the third (THE OSMONDS). The most immediate forms of external feedback were published comments by TV critics and the Nielsen "overnight" audience ratings for New York. Most of the reviews were favorable but some (including the New York Times) were quite critical, and the ratings declined after the premiere to about an average level for prime time programming on PBS. The ongoing formative research program also indicated that early programs in the series were not as appealing as had been hoped; they rated below the appeal of the pilot program tested during the summer. (A revised version of this program was used as the third show in the series and was again well received by test audiences.) The Nielsen ratings indicated that the programs were not being sampled by large numbers of people, for whatever reasons--the day and time of broadcasts, the concept of the programs, the kind and amount of publicity, critical reviews, and so on. It also became clear that repeat viewing was not high (presumably a function of program appeal), although it should be noted that three of the early programs were broadcast on Thanksgiving eve, Christmas, and New Year's Day.

Some of the basic premises for the series, which dated back to the proposal written two years earlier, were questioned once again. Several media strategy questions were also raised as to whether the series, in trying to attract the non-motivated audience by presenting information through a vehicle of light entertainment, was satisfying adequately either the expectations of those with already-high interest in health topics or the appetite for entertainment of the non-motivated audience members.

Although no summative evaluation data were yet available on the early programs' impact on viewers, a CTW administrative decision, concurred in by the series' major backers, was made after six programs had been aired to change approach and format. The originally scheduled one-hour programs would be terminated after the 11th program on January 29, 1975, and the new series would begin April 2 the beginning of a new quarter-year (13-week) television period.

FEELING GOOD was therefore off the air during February and March, 1975, returning on April 2 for a 13-week season in a singificantly changed form:

1) the length of the show was changed from an hour to a half-hour;

2) the Mac's Place segments were dropped;

3) Dick Cavett was added as the host;

4) each show treated a single topic rather than multiple topics;

5) coverage of the original list of behavioral goals was no longer deemed critical;

6) primary emphasis was changed from behavior motivation to affective impact and information gain; and

7) greater stress was given to topics believed by the production staff to be most suitable for interesting television treatment and appeal to general audiences.

The decision to introduce such changes in mid-series had a major impact on all components of the project system--management, production, promotion, distribution, utilization and evaluation. The effect of the changes on the summative evaluation process is covered in detail in Chapter Two.

Coverage of Topics by Program Number and Air Date

The topics treated in the Season A and Season B programs are listed below.

Season A

Program No.	Air Date	Topics
A-1	Nov 20, 1974	Mental health, prenatal care, nutrition
A-2	Nov 27	Weight control, children's vision and hearing, heart disease, allied health personnel
A-3	Dec 4	Breast cancer, hypertension, immunization, exercise, dental care
A-4	Dec 11	Patients' rights, nutrition (cholesterol), alcoholism, child care (preparing children for a new baby)
A-5	Dec 18	Nutrition (fruit), doctor/patient communication, medical emergencies (first aid for cuts and poisoning), uterine cancer (Pap test)
A-6	Dec 25	Health insurance, prenatal care, dental care (sugar)
A-7	Jan 1, 1975	Teenage alcohol abuse, nutrition (variety in meals), prevention of heart problems, alcoholism
A-8	Jan 8	Hypertension, medical emergencies, child care (language development)
A-9	Jan 15	Dental care, health insurance, doctor/patient communication, nutrition and heart problems, prenatal care
A-10	Jan 22	Hypertension, alcoholism (drinking and driving), children's hearing, child care (preparing child for hospitalization)
A-11	Jan 29	Doctor/patient communication, medical emergencies (burn treatment), child care (preparation for life change), allied health personnel (career opportunities), colon-rectum cancer

Season B

Program No.	Air Date	Topics
B-1	April 2, 1975	Aging (home care of elderly)
B-2	April 9	Alcoholism
B-3	April 16	Heart attacks (recovery and prevention)
B-4	April 23	Vision (amblyopia and glaucoma)
B-5	April 30	Breast cancer
B-6	May 7	Stress
B-7	May 14	Doctor/patient communication
B-8	May 21	Depression
B-9	May 28	Hearing
B-10	June 4	Adolescence
B-11	June 11	Alternatives to drug/alcohol abuse (teens)
B-12	June 18	Smoking
B-13	June 25	Weight Control

This concludes the summary background information on the development of the FEELING GOOD series; additional descriptive material appears in Appendix G. Chapter Two describes the concurrent development of the summative evaluation plan.

CHAPTER TWO: THE SUMMATIVE RESEARCH PLAN

Background and Development

Some general features of the summative research plan were set as early as November, 1972, in the proposal to produce the series:

1) The design would be developed by the CTW research staff in cooperation with a Research Advisory Committee.
2) The summative research plan would probably not be able to address every goal programmed in the series.
3) A variety of methodologies would probably be required.
4) The summative research would be contracted by CTW to outside research organizations.

In early 1973, before the Research Advisory Committee was established, the CTW research staff listed a variety of design possibilities for use in discussions with ad hoc advisory groups. In June and July, 1973, these groups met twice to begin setting guidelines and priorities for the summative evaluation program. (See Appendix D for a list of the participants.) Recommendations from these discussions were summarized in the CTW Health Series Phase II Progress Report of August 30, 1973, and are typified here by the following:

1) Control the research sufficiently to permit unambiguous attribution of measured effects.
2) Given the budget limitations and the trade-offs between breadth and depth, give higher priority to more comprehensive studies, even though they may have to be conducted on less than a national basis.
3) Focus on informational and behavioral goals among home viewers.
4) Attempt to measure word-of-mouth influences on both viewership and health behaviors.
5) Be sensitive to possible message distortions and other unanticipated effects.

6) Supplement pre-post measures with interim measures during the six-month series.

7) Minimize, and if possible, isolate, unwanted reactive effects of measurement and treatment.

8) Develop and employ unobtrusive indicators of impact.

9) As an economy measure, consider participating in one of the multiple-sponsor national survey services.

10) Try to assess the effectiveness of various influence strategies used in the series.

In January, 1974, a CTW working paper summarized the previous summative research discussions, solidifying the general strategy of employing a "package" of multiple designs, each having distinctive strengths and weaknesses, and each having its weaknesses compensated for by other designs in the array. Fifteen desired features of the package were phrased as criterion questions which were to be addressed to all component designs. The goal was to arrange the complementarities in such a way that at least one design in the package would be responsive to each criterion. (These criterion questions will be used later in this chapter to assess the design package actually employed.)

The Research Advisory Committee was formed in May 1974, and three meetings were held before the November 20 premiere of the series. In its first meeting, in June 1974, the committee discussed a cluster of design ideas, developed from Phase II discussions and illustrating the design "package" concept. A revised set of designs, shaped by various objectives and constraints, resulted from this meeting.

Alternative Design Considerations

Before describing the designs actually employed, some of the design alternatives that were explored but not selected for various reasons will be examined. Of particular interest were ways to overcome one of the most common problems in mass media research: self-selection biases. Webb and Campbell* write:

> Those who seek out a particular type of television program, or watch public affairs programming on television in general, may be a very different population from either those who do not look at television at all or those who shun such heavy program content. Thus, we may have a comparison between two different populations with different trends and different responsiveness to testing and other historical events. . . . To achieve control over selection biases, ideally the experimenter should randomly assign his respondents to experimental and control treatments. In mass communication research, this is often impossible, but it is and should be standard practice both in laboratory experiments and in those communications studies where random assignment may be possible but less convenient. . . .

The problem stated above (self-selection biases) and the potential solution (random assignment to treatment and control groups) were a major focus of discussions held in June and July, 1974 with a three-member group of research consultants to the Robert Wood Johnson Foundation (one of the major backers of the series), and with some of the members of the Research Advisory Committee. The possibility of establishing a true field experiment in multiple cities--with random assignment of cities to viewing (signal available) and nonviewing (signal unavailable) treatment conditions--was considered.

During and following those discussions, five design alternatives, each yielding a true field experiment, were explored:

1) Design Alternative. Randomly assign one member of each of several pairs of cities to an "exposed" and one to a "non-exposed" condition. Draw the pairs from a pool of perhaps 18 modest-sized cities lacking PBS signals. Arrange to have local commercial stations carry FEELING GOOD in the exposed cities.

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*Eugene J. Webb and Donald T. Campbell, "Experiments on Communication Effects," in Handbook of Communication (Ithiel de Sola Pool et al., eds.). Chicago: Rand McNally, 1973, p. 945.

Analysis. Several commercial stations were contacted regarding this possibility, but all rejected the idea of providing free exposure during prime time, when FEELING GOOD was scheduled to be aired on PBS stations. In addition, non-PBS cities posed other problems: (a) large urban areas would be excluded, as all such areas have a PBS station; (b) the outreach efforts of the Community Education Services division of CTW would not be active in non-PBS cities.

2) Design Alternative. Randomly assign some PBS cities to a non-exposed condition, and withhold the series from those sites.

Analysis. It was judged unreasonable to ask selected PBS stations to refrain from airing the new series for purposes of experimental control.

3) Design Alternative. Use PBS cities only, with selected cities airing the programs in advance of the regular broadcast schedule.

Analysis. There was not enough lead time in availability of completed programs to make this feasible. The lack of national promotion for preseason broadcasts would have created noncomparable conditions. The maximum measurement interval would have covered only a portion of the series. Any seasonal variations or national nonseries health campaigns would have increased noncomparability.

4) Design Alternative. Randomly assign some PBS cities with low-reach UHF stations to receive supplemental broadcasts on commercial VHF channels. Compare with similar UHF cities not receiving supplemental broadcasts.

Analysis. As in the case of Design Alternative #1, it was not possible to obtain appropriate air time on commercial stations.

5) Design Alternative. Present the series on a cable-TV system to some households within a single city and withhold it from similar households in the same city.

Analysis. The possible use of a Canadian cable system, not bound by U.S. regulations to carry available PBS signals, was explored, but the site investigated would have been "contaminated" by promotional materials crossing the border, and the informational referrals would not have been appropriate for Canada.

Other ways of accounting for self-selection biases were also considered:

e.g., (a) letting those predisposed to view the series identify themselves through actual initial viewing behavior, then inducing a randomly-assigned portion of these identified viewers to not view the remainder of the series; and (b) comparing viewers of a particular program on program-specific measures with persons who did not view that program, but did view other programs in the series (and had thus demonstrated a propensity for self-selection). (The latter plan was subsequently used in one of the summative research studies.)

However, the alternatives described above could not be pursued for various reasons. The final design package adopted in the summer of 1974 represented the judgment by CTW research staff, considering all advisory inputs, as to the best combination of what was desirable and what was possible. The five-study design package included:

1) A multiple-city, large-sample study of voluntary viewing in a natural setting.

2) A field experiment in a community with good representation of low-income and minority audience members.

3) A series of four national surveys to measure trends of awareness, sources of awareness, viewing of the series, and selected health behaviors.

4) A community monitoring study in which nonreactive institutional measures, such as type and frequency of visits to local health care centers, could cross-validate self-reports of series effects.

5) National audience estimates for the series, as provided by Nielsen ratings.

Each study is discussed in later sections of this chapter.

The Initial Summative Research Program

Introduction. Four research organizations, each operating independently under contract to CTW, conducted the five-study summative research program on FEELING GOOD. In relative terms, two of the studies were extensive and complex, while the remaining three were more limited in scope. The two larger studies (the four-city study of voluntary viewing and the induced viewing study) were affected significantly by the mid-series change to Season B, thus requiring both Season A and Season B rationales for the original and revised designs.

The Response Analysis Corporation (RAC) of Princeton, New Jersey, conducted the four-city study of voluntary viewing. Dr. Herbert Abelson, President of RAC, served as Project Director; Morris Cohen, Associate Project Director, was responsible for day-to-day administration of the project. The RAC final report, entitled "Impacts, Benefits, and Consequences of FEELING GOOD," consists of seven volumes/subvolumes, including main findings, methods and procedures, and detailed tabulations. The nature of the present report permits coverage of only the major features of the design. Full descriptions of technical features of the study are provided in the RAC report.

The National Opinion Research Center (NORC), a unit of the University of Chicago, conducted the induced-viewing study in a Dallas, Texas, low-income community. (NORC also initiated an exploratory and supplemental study on monitoring of health care facilities, but, as will be detailed later, this study could not be completed.) Dr. Edmund D. Meyers, Jr., was the Project Director during the data collection phase of this study, and Mary C. Burich had major responsibility for the field operations. When Dr. Meyers left NORC in July, 1975, Drs. Norman M. Bradburn and Michael J. Minor completed the analysis report, entitled "The Effects of Viewing FEELING GOOD: Results from a Field Experiment in a Low-Income Community". This two-volume report (Final Report and Appendices) also contains more detail than can be included here, and interested readers are encouraged to examine the entire NORC report.

The two remaining studies of FEELING GOOD were less complex because they were incorporated into routinized and ongoing research services. Four national surveys, conducted by the Gallup Organization, Princeton, New Jersey, were incorporated in their "omnibus" or multiple-sponsor survey services. Dr. Irving Crespi, Executive Vice President of the Gallup Organization, served as Project Director. Separate reports under the general title "The National Audience for FEELING GOOD" were submitted for each of the four surveys. Audience estimates for the entire duration of the series were provided by standard Nielsen ratings services, coordinated through the office of Mr. Ralph T. Clausen, Vice President, A.C. Nielsen Company, New York.

The Four-City Study of Voluntary Viewing: Original Design

The general goal of the four-city study, conducted by the Response Analysis Corporation (RAC), was to assess selected cognitive and behavioral effects of FEELING GOOD on a large geographically-varied sample of volunteer viewers.

The RAC proposal made reference to certain methodological issues and realities that influenced their proposed design:

1) The typical adult audience for PBS programming in prime time is small. It would therefore be inefficient to sample on a simple random basis, because the expected yield of viewing homes per 100 homes sampled could well be less than 5. The proposed solution was to stratify respondents in terms of likelihood of viewing, then oversample from the "high likelihood" group.

2) Although it was highly desirable to have a true control group, which would in this case consist of comparable cities without access to FEELING GOOD, this was judged not to be feasible (for many of the same reasons cited in Chapter II: Alternative Design Considerations).

3) The six-month duration of the series meant that it would be difficult to track viewership patterns and program-specific effects with a simple pre-post procedure. The proposed solution was to use 10% of the pretest (or baseline) respondents for each of 10 interim measures, to be spaced approximately every two weeks throughout the series (in addition to the regular posttest measures).

4) The repeated measurements (pretest and interim measures) could possibly have effects independent of or interactive with the series: e.g., heightened awareness of health issues, and learning from the questionnaire itself. To estimate such effects, if any, a panel control group was proposed that would not be pretested or measured during the series.

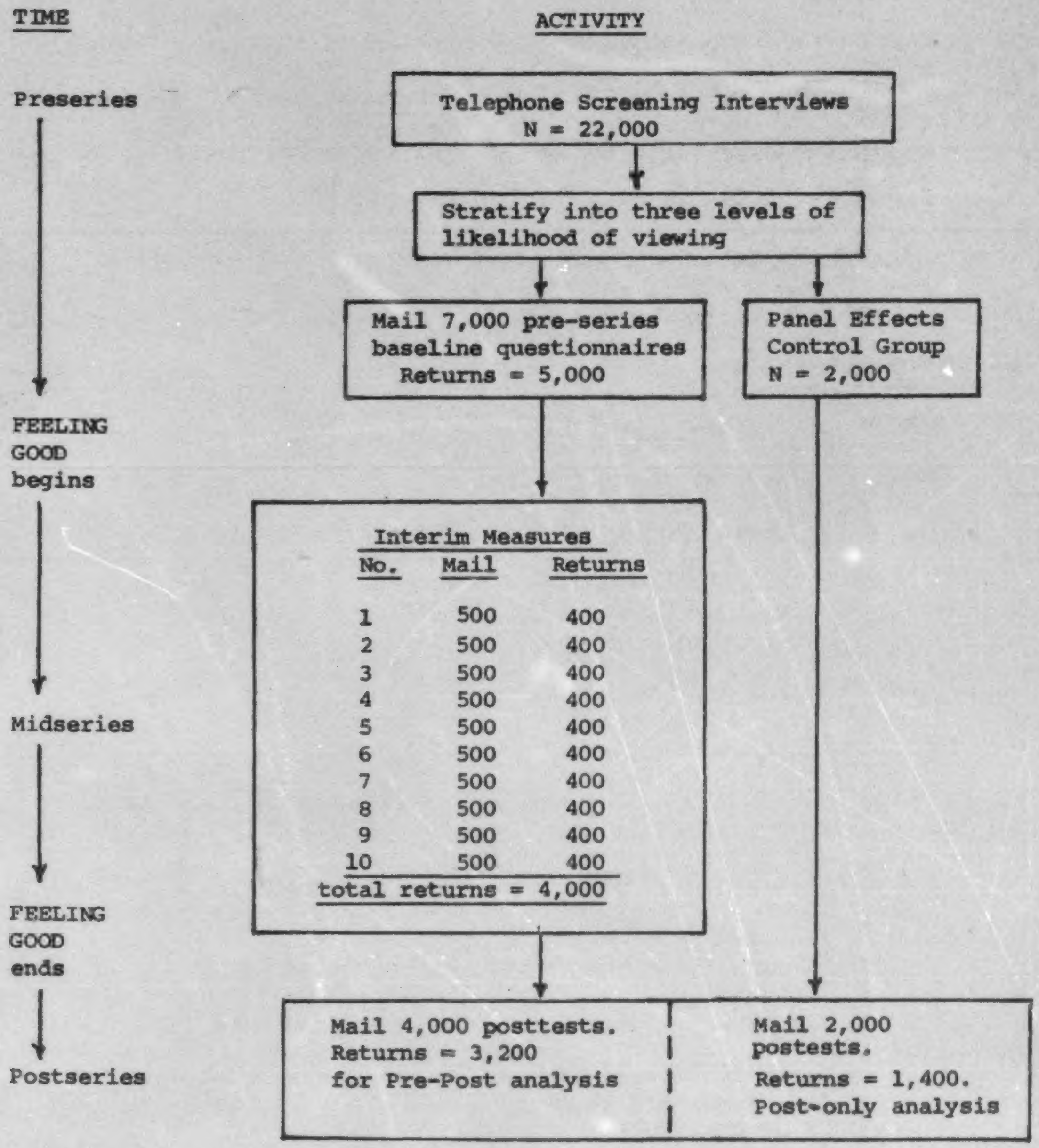
The cities of Boston, Dallas, Seattle, and Jacksonville (Fla.) were chosen as test sites because of their geographic spread, the minority group representations in their audiences, and their strong VHF signals. Funding limitations precluded expansion into the six or eight cities originally desired.

The design originally established for the entire 26-week series will be summarized here (see graph). Since some of the sequential steps in the original design were implemented in Season A and others were not (being subsequently altered in Season B), the Ns and questionnaire return rates used for the description of the entire design will be those of the original "pre-implementation" plan.

Random-digit dialing in the four cities was to generate 22,000 telephone interviews, used to stratify respondents into high, medium, and low levels of likelihood of viewing FEELING GOOD. High-likelihood viewers and women were then to be oversampled to establish a baseline group of 7,000 to be pretested, and a panel control group of 2,000 which would not be pretested. Mail questionnaires, with a $1 incentive, were to be used for all measures after the screening interviews. From the pretest or baseline group, 5,000 usable questionnaire returns were expected.

Ten interim measures were scheduled throughout the series, spaced about two weeks apart, with independent samples of about 500 respondents each. Two interim measures (after programs A1-4 and A5-8) were implemented according to the original plan. The third interim measure, covering programs A9-11, was influenced by the change to Season B. Some of the interim measures were to

ORIGINAL DESIGN FOR RAC FOUR-CITY STUDY


TIME
ACTIVITY
Preseries
Telephone Screening Interviews
N = 22,000
Stratify into three levels of likelihood of viewing
Mail 7,000 pre-series baseline questionnaires
Returns = 5,000
Panel Effects Control Group
N = 2,000
FEELING GOOD begins
Midseries
FEELING GOOD ends
Postseries
Mail 4,000 posttests.
Returns = 3,200
for Pre-Post analysis
Mail 2,000 postests.
Returns = 1,400.
Post-only analysis

Interim Measures

No.	Mail	Returns
1	500	400
2	500	400
3	500	400
4	500	400
5	500	400
6	500	400
7	500	400
8	500	400
9	500	400
10	500	400

total returns = 4,000

be geared to specific episodes of FEELING GOOD, and the resulting data analyzed independently within each wave, while other interim measures were to constitute a common and repeated battery of items on health behaviors for the purpose of plotting trends throughout the series.

The posttest was to be administered to all baseline and panel control respondents after completion of the 26-week series, with the major analytic model to be comparisons of baseline to posttest, viewers vs. nonviewers. To increase precision and partially isolate self-selection biases, if any, at least two levels of viewers were to be matched to nonviewers on several demographic and psychological variables, drawn from the preseries baseline data. As will be detailed in a later section of this chapter, the design and the analytic models were altered significantly by the midseries change to Season B.

Among the strengths of the original RAC design were the following:

1) The test sites were geographically widespread.

2) All test sites had strong PBS stations, with heterogeneous socioeconomic levels and ethnic groups in the coverage area.

3) Economics of mail questionnaire methodology permitted large samples, which, in turn, permitted various subgroup analyses.

4) Previous RAC experience with mail questionnaires led to the expectation of a high return rate.

5) The sample was drawn randomly, then stratified into levels of likelihood of viewing. Oversampling high probability viewers gave greater assurance of getting measures on substantial numbers of viewers.

6) Preseries/postseries comparisons could be made.

7) Heavy and moderate viewers could be matched on several factors to nonviewers on preseries status, partially isolating possible effects of self-selection.

8) Short-term and special program-specific effects could be estimated via 10 interim measures, spaced throughout the series.

9) By overlapping slightly the intervals covered in the interim measures, sample sizes could be effectively doubled (500 to 1,000) for some items.

10) The interim measures would permit series-long plotting of (a) viewership proportions, and (b) trends in a common battery of health behaviors.

11) The design incorporated a method of estimating effects, if any, of pretesting and interim measures.

Among the weaknesses of the original RAC design were the following:

1) The approximation of a control group by post-hoc matching was not complete assurance that viewers were equivalent to (not significantly different from) non-viewers in all respects other than viewing FEELING GOOD.

2) The mail methodology precluded on-site checks on which household member actually completed the questionnaire. (Telephone validations on a subsample were planned but had to be dropped for budgetary reasons.)

3) With mail questionnaires, opportunities for follow-up questions were extremely limited, and had to be built in to the questionnaire from the beginning.

4) Even with relatively high return rates, the cumulative attrition could be substantial, thus affecting the randomness or representativeness in unknown ways.

5) The length and complexity of items that can be asked in mail questionnaires are limited.

6) High confidence could be placed in program-specific viewing data from the interim measures, but any particular interim measure would cover only 10% of the pretested respondents. Posttest assignment into categories of viewership would necessarily depend on long-term recall, and thus would not be precise as to overall number of programs viewed or which particular programs were viewed.

Induced Viewing Field Experiment. The major goal of the induced viewing experiment, conducted by the National Opinion Research Center (NORC), was to ascertain the effects of viewing FEELING GOOD on a hard-to-reach audience of women with predominantly minority and low-income characteristics. This important segment of the target audience for FEELING GOOD presented significant methodological challenges, because of several indications that the PBS adult audience is skewed toward the more affluent. CTW had faced a similar challenge earlier with the SESAME STREET series for preschoolers and had learned that special audience-building and outreach efforts might be required for two or more years before relatively high penetration of low-income and minority audiences was achieved. Estimates of effects among low-income and minority adults were desired as soon as possible for FEELING GOOD, however, and since other designs in the summative research program had limited prospects of providing this information, a special study that addressed the issue directly was needed.

In view of the problems of experimentally manipulating the availability of FEELING GOOD, NORC decided to experimentally induce a randomly-assigned portion of this audience to view the entire series and compare them with similar persons not induced to view.

NORC/CTW hopes were that a substantial inducement, such as payment of $50, would result in viewership of at least 80% of the potential viewing instances (number of induced respondents x number of programs). Previous ratings histories led to the expectation that "contamination" of the control group through uninduced viewing would initially be minimal among these audiences--almost certainly less than 5% of the potential viewing instances. The strategy thus depended on a two-step process: the presence or absence of the inducement procedures would be uniform within the randomly-assigned treatment groups, but consequential viewing/nonviewing, not being directly manipulable, would be less than uniform (but hopefully predominant enough to provide a clear contrast of "primarily viewing vs. primarily nonviewing" groups). Such a field experiment would provide useful information difficult or impossible to obtain in other ways.

NORC conducted the induced viewing field experiment in the Oak Cliff section of Dallas. Restriction to a single community meant that many extraneous factors such as the scheduling of repeat broadcasts, the array of available alternative programs on TV, the availability of health/medical services, the potential influences of other health campaigns, and the like, would be approximately equal for experimental and control groups. KERA-TV (the local PBS station) produced a strong VHF signal; NORC had a field staff in Dallas; and census data indicated that the Oak Cliff area matched the desired sample specifications very well: about 25% black, 25% Hispanic origin, and 50% annual income less than $7,500.

Sampling areas or segments were drawn by probability methods from Oak Cliff census tract data. Segments were assigned at random to the various treatment conditions (to be described later). Using block quota sample techniques, respondents were screened for a working TV set and good reception of KERA-TV. There was also a quota requirement that 50% of the households have at least one child under six years of age. Females classified as heads of households (or primarily responsible for the health care of children) were used exclusively as respondents.

An early version of the NORC proposal for this study suggested the following design:

Induced Viewing Group Beginning N = 250 Postattrition N = 200	Noninduced Control Group Beginning N = 250 Postattrition N = 200
Preseries baseline measure (N = 250)	Preseries baseline measure (N = 250)
Interim Measure # 1 (N = 240) 2 (N = 230) 3 (N = 220) 4 (N = 210)	
Postseries measure (N = 200)	Postseries measure (N = 200)

After discussions with CTW research staff, but before going into the field, NORC modified this design to build in a means of estimating not only the effects of viewing the series, but also of assessing possible effects of inducement (payment), and effects of the repeated measures throughout the series that might otherwise be irretrievably confounded with viewing effects. This more complex version is called the NORC "original" design (to contrast it with the later modified design actually used when the broadcast schedule was interrupted for eight weeks).

In graphic form, the "original" NORC design; i.e., the design developed before the series began, and intended as the series evaluation plan, was as follows:

	A						B			C	
Treatment Group:	INDUCED VIEWERS						INDUCED NONVIEWERS			NONINDUCED NONVIEWERS	
Treatment Procedure:	$50 payment to view entire series, and to be interviewed repeatedly.						$20 payment for interview coop.; no mention of F.G.			No payment; no mention of F.G.	
Subsample:	1	2	3	4	5	6	1	2	3	1	2
Postseries Subsample N:	100	25	25	25	25	25	25	75	25	75	25
Preseries Baseline Measure:	X	X	X	X	X		X	X		X	
Interim Measure 1:	X						X				
Interim Measure 2:	X	X					X				
Interim Measure 3:	X		X				X				
Interim Measure 4:	X			X			X				
Postseries Measure:	X	X	X	X	X	X	X	X	X	X	X

Among the strengths of the NORC design were the following:

1) It gave the highest possible probability (short of "captive audience" group tests of motivated persons in laboratory settings) of sustained exposure to the

entire series among an important element of the target audience that was otherwise initially very difficult to reach.

2) Sustained exposure during the series was considered important for at least one study in the overall summative research program, because multiple scheduling of multiple topics, when overlaid with spotty and unique patterns of viewing, would make it very difficult to link specific effects with specific series treatments. There could, of course, be no presumption of a program's effect within the series in the absence of viewing that program. The interim measures would allow program-specific identification of all actual viewers in the induced viewing group.

3) Up to the point where respondent quotas were used within blocks, selection of household locations and assignment into treatment groups were random.

4) The design permitted small subsamples to be used for estimating what effects, if any, could be attributed to nonseries influences; specifically, effects of payment and effects of repeated measurements. The major purpose was not to conduct an experiment on methodology, but to assess impact of the series. For budgetary reasons, these extraneous influences had to be estimated on the basis of small subsamples, to see whether or not caveats or qualifications would be required in interpreting the major analyses of pre-post, experimental-control group comparisons.

5) Although not a research priority, there was at least the possibility that this experiment could provide policy-relevant data regarding broader application of inducement techniques to reach difficult audiences in a cost-effective manner with mass media social action programming.

Among the weaknesses of the NORC design were the following:

1) Payment for viewing introduced an issue of external validity--whether one could generalize from an artificially induced audience to an uninduced voluntary audience.

2) The independent variable of experimental interest--viewing vs. not viewing--was not directly manipulable, but had to be a consequence of the manipulable factor of inducement. No advance quarantees of actual viewing or not viewing were possible.

3) For factors other than those made homogeneous via respondent selection, sample sizes were too small (again, for budgetary reasons) to allow much analytic subdivision.

4) Any factors unique to the Oak Cliff community would limit the generalizability of findings.

The Community Monitoring Study. This study was initiated, but not completed, by NORC as an exploratory project, to complement the induced viewing field experiment in Dallas. There were two goals: (1) to see what institutional changes, if any, might be associated with the series; and (2) to validate some of the self-report measures collected in the induced viewing experiment. An inventory of available services would also have made it possible to estimate the extent to which types of health care mentioned or recommended by the series were in fact available to the Oak Cliff area residents.

NORC planned to determine from summary records the levels and patterns of demand for health services in Oak Cliff during the run of the series. (According to NORC, services were provided by three hospitals, a public health care center, twelve storefront health clinics, and a number of private doctors.) The problem was that adequate summary records were not available, contrary to earlier assumptions, and there was neither time nor budget to develop alternative procedures. The project was reluctantly terminated even before Season B began.

National Surveys. The Gallup Organization conducted four surveys to establish nationally-generalizable trends throughout the series for awareness of FEELING GOOD, incidence of viewing, and incidence of various health practices. The surveys were based on independent national probability samples of interviewing areas, and each involved personal interviews with approximately 1,500 adults.

While the RAC and NORC studies entailed in-depth data collection in limited sites, the Gallup surveys concentrated on obtaining as much breadth as possible (without probes) with a few items. The viewing measures served as a supplement to the Nielsen ratings. The self-report data on health practices provided comparative references for the four-city study of voluntary viewers and the induced-viewing field experiment. In addition to providing the only data on national awareness of the series, the surveys were intended to aid in the interpretation of findings produced by each of the other studies.

The assessment of health practices was based on a "behavioral checklist" of 14 to 15 items, most of which were common to all four Gallup surveys. Items were introduced thus: "Just thinking of the past two months, that is, since (date), which if any of these (health care behaviors) have you done?" As a check on possible inflation of affirmative responses caused by reporting of behaviors that occurred more than two months earlier, the last two Gallop surveys asked half the samples to respond first for a six-month time frame, and then for a two-month time frame.

Gallup surveys were conducted after the second and third programs of Season A (December 3-8, 1974), immediately after the end of Season A (February 1-3, 1975), after the third program of Season B (April 18-21, 1975), and after the ninth program of Season B (May 30-June 1, 1975). The field dates were scheduled to coincide with the testing intervals in the other studies.

The description of the design and sampling procedures is included in the Gallup report and is not reported here.

National Audience Estimates. The A.C. Nielsen Company estimated the audience viewing the series each week throughout the broadcast season. Nielsen's standard national sample of homes equipped with an Audimeter was supplemented with a separate national sample of households in which viewing diaries were maintained. In addition to measuring the audience for each

SUMMATIVE RESEARCH PLAN FOR FEELING GOOD

ASSESSMENT OF DESIGNS IN TERMS OF SPECIFIC DESIRED FEATURES FOR THE TOTAL SUMMATIVE RESEARCH PROGRAM

The Studies:

I. Four-city study
II. Induced viewing study
III. Community monitoring
IV. National sample surveys
V. Nielsen

	I 4-City Study	II Induced Viewing Study	III Community Monitoring	IV National Surveys	V Nielsen
1. In this design, is it possible to assess the progressive steps leading toward the terminal objectives, so we can analyze how far we got in each goal area?	partially	partially	no	no	no
2. Can this design incorporate or control for other health education campaigns going on at the same time?	no	yes	no	no	no
3. Can the results of this design demonstrate a connection between FEELING GOOD and the measured effects?	yes	yes	partially	no	no
4. Can this design assess the impact on the size and composition of the PBS audience?	local only	no	no	yes	yes
5. Can information gain be measured in this design?	yes	yes	no	no	no

Summative Research Plan for FEELING GOOD (Cont'd.)	I 4-City Study	II Induced Viewing Study	III Community Monitoring	IV National Surveys	V Nielsen
6. Can actual behaviors and behavior changes (not self-reports) be monitored in this design?	no	no	yes	no	no
7. Is it feasible to incorporate measurements of word-of-mouth influences in this design?	possibly	yes	probably not	no	no
8. Is it feasible for this design to account for the dual variables of (a) amount of program coverage, and (b) amount of viewing for a particular topic?	partially	yes	no	no	no
9. Is it possible in this design to reach conclusions on effects other than effects on individual viewers? (e.g., effects on institutions)	no	no	yes	no	no
10. Will this design provide data relevant to analysis of cost/effectiveness ratios?	yes	yes	partially	yes	yes
11. Can results from this design be generalized to a national population?	no	no	no	yes	yes
12. Can this design generate early feedback, in time for second-season decisions?	yes	yes	no	yes	yes
13. In this design, is it possible to guarantee in advance special consideration of the needs of the poor?	no	yes	yes	no	no

Summative Research Plan for FEELING GOOD (Cont'd.)

		II	III	IV	V
	4-City Study	Induced Viewing Study	Community Monitoring	National Surveys	Nielsen
14. Can this design assess the impact of follow-up programming and community utilization efforts?	no	partially	no	no	no
15. Will this design be especially sensitive to unexpected effects, both beneficial and non-beneficial?	no	partially	partially	no	no

program, Nielsen ran separate analyses for some programs to provide breakdowns of viewers by age, sex, income, and education, as well as estimates of repeat viewing by households.

Collective Assessment of the Designs. The package of five interrelated studies described above comprised the summative research program for FEELING GOOD as the series began. In an early section of this chapter, it was stated that fifteen criterion questions provided guidelines for the development of the total research program. A CTW paper dated October, 1974, assessed the five studies on these criterion questions (see preceding table).

Effects of the Change to Season B on the Summative Research Designs

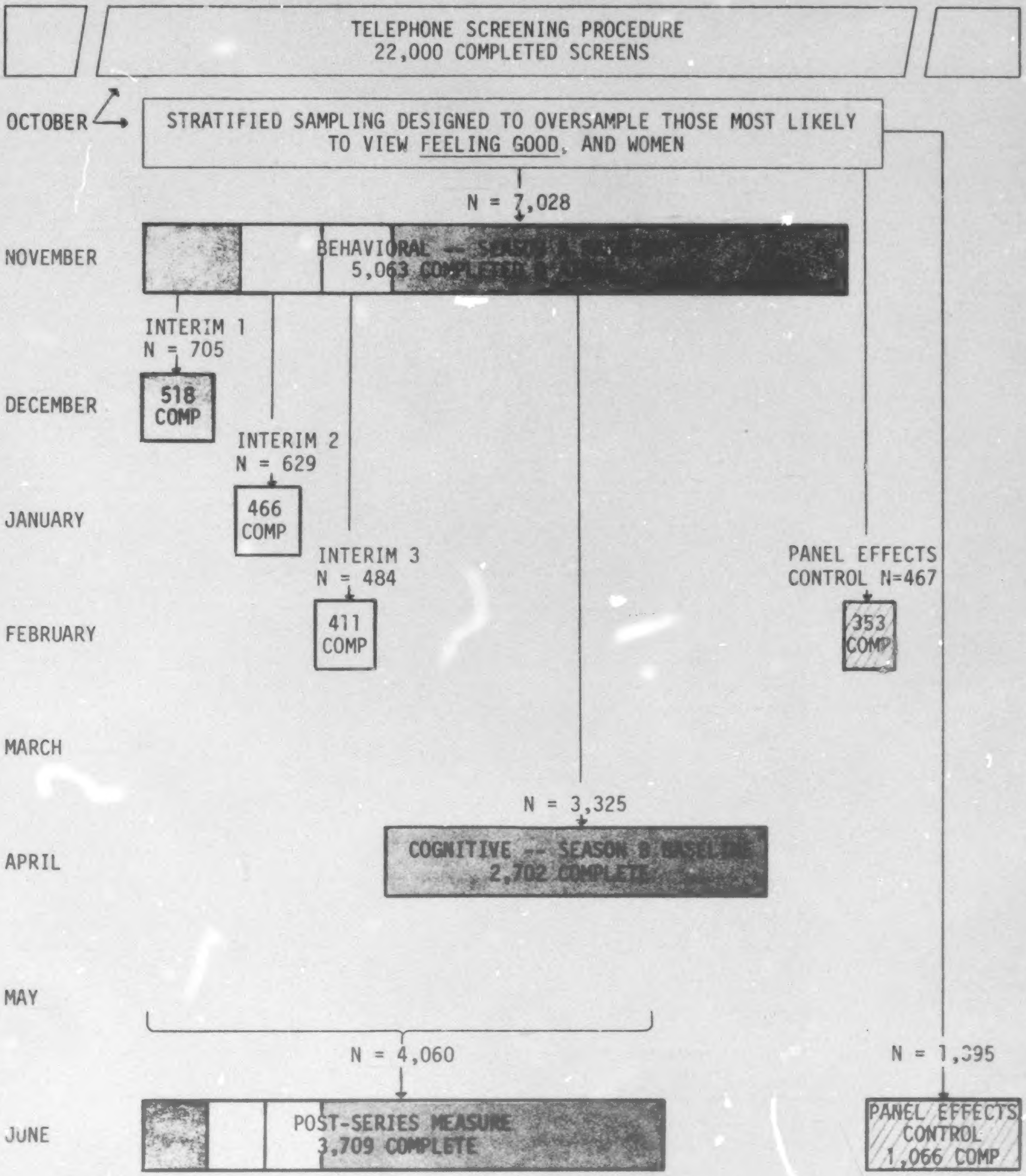
The termination of the one-hour FEELING GOOD programs on January 29, 1975 after 11 programs (Season A), the two-month "down" time, and the return with 13 Season B programs on April 2 caused severe problems for RAC's four-city study and NORC's induced viewing study. The Gallup surveys and the Nielsen services were minimally affected. In an attempt to adapt the complex study designs to changes in program length, series length, program objectives, topics, and air dates, the CTW research staff held a number of discussions with RAC and NORC during January, February, and March of 1975.

Revisions in the Four-City Study of Voluntary Viewing

Before the end of Season A, the original RAC design had progressed through the screening interviews, the preseries baseline measure, and the first two interim measures (through program A-8). After discussion of numerous alternatives, the revised design presented below was worked out as the most reasonable option, and was implemented as shown.

Some of the major considerations that influenced the design revisions in the four-city study were as follows:

Research Procedure for Feeling Good (RAC)


TELEPHONE SCREENING PROCEDURE
22,000 COMPLETED SCREENS
OCTOBER
STRATIFIED SAMPLING DESIGNED TO OVERSAMPLE THOSE MOST LIKELY TO VIEW FEELING GOOD, AND WOMEN
N = 7,028
NOVEMBER
BEHAVIORAL -- SEASON A BASELINE
5,063 COMPLETED [illegible]
INTERIM 1
N = 705
DECEMBER
518 COMP
INTERIM 2
N = 629
JANUARY
466 COMP
INTERIM 3
N = 484
PANEL EFFECTS CONTROL N=467
FEBRUARY
411 COMP
353 COMP
MARCH
N = 3,325
APRIL
COGNITIVE -- SEASON B BASELINE
2,702 COMPLETE
MAY
N = 4,060
N = 1,395
JUNE
POST-SERIES MEASURE
3,709 COMPLETE
PANEL EFFECTS CONTROL
1,066 COMP

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*Segments do not add to total due to follow-up procedures employed. See Volume 2, Methodological Report, for full methodology.

1) All modifications would have to be made within the existing budget.

2) Since there was a need to obtain some interpretable data on all 11 Season A programs, without jeopardizing the interpretability of Season B data, approximately one-fourth of the panel effects control group was tested at the third interim measure (covering programs A-9 to A-11) to serve as an "end of Season A readout".

3) Season B was to be essentially a new series, and the original Season A baseline measures would have only partial relevance to the new content. A new Season B baseline measure was therefore required, and with substantially larger sample size than the 500 originally allocated to interim measures. Thus, interim measures were abandoned entirely for Season B, in order to provide about 3,000 respondents for a Season B pre-post analysis.

4) Since Season B was to cover only one topic per program, it was considered essential to index program-specific viewing patterns for each respondent. The maximum ability of a respondent to recall program-specific viewing (with content descriptions provided) was estimated to be six programs. This was one of several reasons why all of Season B could not be covered in the evaluation. (Other reasons included CTW's inability to specify with enough lead time the Season B scheduling of topics, and the anticipated drop-off in response rates after the later ending date (June 25) for the series.)

Among the implications and consequences of the design revisions were the following:

1) Any Season A pretest item repeated on the Season B posttest would be in effect a delayed posttest, with a delay interval of over four months, making significant differences less likely, and making interpretation more difficult.

2) The power of the panel effects control group was weakened by dividing it into two reduced-N groups.

3) Some measures on the Season A pretest were addressed to content scheduled for programs 12 to 26--programs that were not aired. No follow-up comparisons are possible on these items, and the data they produced could be used only for descriptive purposes.

4) Given the limits in length for a mail questionnaire, the inclusion of Season B pre-post cognitive material

meant a limit on the number of Season A items that could be repeated on the Season B posttest.

5) The revised design required a greater variety of data analysis models, and some of the originally-planned pre-post comparisons were precluded.

Although changing the evaluation plan so significantly in midstream obviously caused major problems, the modified design provided what was judged to be the best recourse under the circumstances and sufficiently useful as a partial assessment of effects of both Seasons A and B to warrant continuation.

In the RAC report, several different analysis models were required to accommodate the various types of data generated. The screening and baseline interviews provide descriptive data which are simply cross-tabulated by various demographics. The bulk of the comparative analysis, tested for statistical significance, comes from various combinations of--

A: two ways of classifying the independent variable (level of viewing) and

B: two ways of classifying the dependent or effect variable.

Each is discussed below.

A: Classifying Levels of Viewing

A-1 Show-specific viewing. For interim measures in Season A and for Season B posttest measures, self-reports of show-specific viewing were obtained. If content X were covered on show Y, then questionnaire items over content X could be analyzed in terms of viewers vs. nonviewers of show Y. This contrast absorbs, obscures, or is confounded by any self-selection effects, however. If those with high motivation do view and those with low motivation do not view, it is difficult to separate effects of viewing from effects of motivation. A third analysis category was therefore added, which provides a partial means of accounting for self-selection effects.

Nonviewers of a particular show were subdivided into (a) those who had viewed other shows within the measurement interval, but not the particular show (Y); and (b) those who had seen neither this particular show (Y) nor any others in the measurement interval, as follows:

Viewers (of show Y)	Viewers of other shows (but not show Y)	Nonviewers (of any show)

It was reasoned that both viewers of show Y and viewers of shows other than Y had demonstrated their tendencies to self-select into voluntary viewing patterns, and therefore probably differed from each other primarily in terms of exposure to the particular show Y. Holding self-selection effects more or less constant, then, the residual effect of viewing show Y can be estimated by comparing viewers of show Y with viewers of shows other than Y. It also follows that one estimate of the magnitude of the self-selection effect is to compare (on a show Y-specific content X item) the nonviewers of any show with the nonviewers of show Y who saw other shows. Such a three-way division of viewing levels was employed whenever show-specific viewing was obtained and whenever the content item could be associated with a particular show.

It can be argued that show-specific viewing reflects self-selection tendencies not only for health materials in general, but also for specific health topics. The three-category analysis above controls for the former but not the latter. Topic-specific self-selection is believed to be less of a problem in Season A, where multiple topics were treated in each program, than in Season B.

A-2 Overall levels of viewing. Show-specific viewing reports were not obtained from all respondents for all shows; several items were not readily associated with a particular show but rather with a cumulative impact of several shows. The second means of categorizing exposure, therefore, was by three overall levels of viewing:

a) Frequent viewers (self-reported viewing of 4 or more programs in Season A and/or B).

b) Less frequent viewers (1-3 programs viewed).

c) Nonviewers (no Season A or B programs viewed).

In such analysis, there is no guarantee that even a frequent viewer saw the relevant program material for any given content item. The viewing categories are akin to probability levels for exposure to relevant programming.

B: Classifying Dependent Variables

B-1 "Single point in time" dependent variable measures. This refers to such analyses as the interim measures and post-only measures; it contrasts with the pre-post measures below.

B-2 Dependent variable measures related back to pretest position. This was typically done in a four-category fashion, as shown below, where "+" indicates a correct answer or presence of an advocated behavior, and "-" indicates the opposite.

PRETEST	+		-	
POSTTEST	+	-	+	-

Both Season A and Season B baselines were partially incorporable into this model. In some instances, it was possible to assess posttest outcome measures (knowledge or behavior) utilizing only target audience respondents who identified themselves by not reporting the desired knowledge or behavior on the pretest. The four analysis models resulting from various combinations of the above, and the major types of data analyzed in each model, are summarized below.

	Show-Specific Viewing (Viewers, Viewers of other shows, Nonviewers)	Overall Levels of Viewing: Frequent, Less Frequent, and Nonviewers
Single point in time measures:	Interim 1, 2, and 3. Panel vs. control in Season B posttest	Several series effects measures (RAC chpt. 3)
Pre-post comparisons:	Season B knowledge items	Several series effects measures (RAC chpt. 3)

Some of the main potential problems or limitations of the RAC study as finally implemented, as well as the means of estimating their effects, are summarized below.

1) Panel effects

These are effects not of the TV series, but of repeated measurement per se--such as learning from the questionnaire itself; increased sensitivity to, or salience of, health topics due to repeated measurements; and/or increased viewing of FEELING GOOD as a consequence of special attention. The basic means of estimating the presence and/or magnitude of panel effects was the set of two comparisons with the non-pretested panel control groups.

a. The first such comparison was in the third interim measure. RAC concluded that the viewing behavior in shows A-9 to A-11 did not differ between the pretested and non-pretested respondents. However, the non-pretested control group respondents consistently reported higher levels of behavior and lower knowledge levels than Interim III respondents. RAC reasoned that the control group behavior reports were relatively inflated because of no previous opportunity to register such behavior (hence, telescoping); and the pretested group's knowledge was probably inflated because of learning from previous questionnaires.

b. The second opportunity to assess panel effects was in the Season B posttest measures. Panel effects explored were of two kinds:

(1) repeated interviews without exact question repetition in Season B pre-post cognitive items. No general panel effect was found here.

(2) repeated interviews with exact question repetition in Season B pre-post cognitive items. RAC found "in most instances" that those respondents answering a set of identical questions on B-Baseline, B-Posttest did better on those B-Posttest questions than the non-pretested control group or those who had been tested before, but not on the B-Baseline. The effect of learning from prior questioning varied from item to item. The RAC report gives a general caveat regarding this but does not suggest decision rules for estimating uninflated program effects.

2) Self-selection biases

In this study, no *a priori* attempts were made to regulate or control voluntary viewing patterns. (See earlier "Alternatives Design Considerations" section in this chapter). Nevertheless, there are means, short of random assignment to viewing/nonviewing groups, to estimate whether and to what extent viewing effects may have been confounded by self-selection factors:

a. One control feature, described previously, was to compare (1) viewers of a particular show, (2) viewers of other shows, and (3) nonviewers. RAC analyses using this model did indicate the existence of apparent self-selection biases, varying from item to item, and this model also provides a means of estimating the magnitude of self-selection effects.

b. RAC found no evidence of self-selection biases in the form of preseries demographic differences between subsequent viewers and nonviewers. Distributions on age, sex, education, and presence/age of children at home indicated no difference in November baseline profiles among those who subsequently became (1) Frequent Viewers, (2) Less Frequent Viewers, or (3) Nonviewers.

c. After receiving the RAC report, CTW conducted an analysis with the RAC data tape to see if levels of series viewing were associated with factors other than demographics on the preseries baseline measure. Respondents identified in June, 1975, as heavy, moderate, or nonviewers were examined on their previous response patterns for the entire preseries baseline questionnaire. There were no significant differences among the three viewing groups on more than 80% of the items, but there were indications in some instances that those respondents who later turned out to be relatively frequent viewers were already health-oriented before the series began.

Decision rules for interpreting these data were as follows: Self-selection is indicated by pretest differences among the three groups when: (1) two of three contrasts (high vs. moderate; high vs. nonviewer; moderate vs. nonviewer) are statistically significant; (2) the differences are linear in a pattern consistent with self-selection biases; and (3) the pattern for the two previous conditions holds for the one response option that is of greatest importance for that item. The absolute differences among the groups were relatively small, averaging about 6% for the contrasts which were statistically significant.

Before the series began, persons who became viewers of the series were somewhat more likely than nonviewers to:

- have been told nothing about the status of their blood pressure after it had been taken, and to wish that they knew more about their blood pressure than they were told at the time;

- have suggested to someone else that they get their blood pressure checked, and that a female friend or relative have a doctor examine her breasts;

- agree with the statement that "no matter how careful a person is, he has to expect a good deal of illness in his lifetime";

- have tried in the last six months to get information on where to get a blood pressure check, a heart check-up, and where to get help for a drinking problem;

- report getting more health information "now" (i.e., before the series) from radio and television than they did six months previously, and to have sent away during the last six months for some health information offered on television;

- have given thought to trying to change what their children eat for snacks, and to getting additional shots or immunizations for their child;

- have used a dental disclosing tablet at least once;
- have the number of the local Poison Control Center posted near the telephone; and
- know how to conduct a breast self-examination without the help of a doctor.

Despite the absence of demographic differences between viewers and nonviewers, the findings above suggest that FEELING GOOD attracted a somewhat selective audience in terms of health attitudes and behaviors. Before the series began, the heavy viewer tended to be a health information-seeker, someone who encouraged others to take health measures, a person who gave thought to health matters, who was somewhat fatalistic about health, and who had taken at least some of the health actions that were later advocated on the series. Evidence of self-selection also was apparent in several of the analyses involving program-specific viewing effects.

The existence of self-selection biases is not surprising. The analytic question is the extent to which the effects of viewing can be separated from self-selection effects. In several instances, viewing effects were strong enough to over-ride predispositional differences, as evidenced in the model described in (a) above, and in those analyses where only those respondents not getting an item correct (or not reporting the advocated behavior) on the pretest were analyzed for post-series status by levels of exposure to the series (see Chapter Four for data displays, e.g., on information seeking, and posting the poison control telephone number).

3) Inflation of self-reported health behaviors

Various explanations for inflated reporting include reactivity, telescoping, evaluation apprehension, and social desirability biases. In the absence of external validity checks, no direct estimate of the magnitude of self-report inflations, if any, is possible. On a simple face validity basis, however, certain self-reported health behaviors appear inflated. RAC reasons that any inflations are probably uniform across subgroups, thus not affecting the outcome of subgroup comparisons. By going outside the RAC study, comparisons to other FEELING GOOD studies (especially

> the Gallup split-sample surveys) allow some estimate of the magnitude of possible inflation effects.

Revisions in the Induced Viewing Field Experiment

When the termination of Season A was announced in early January, 1975, NORC had completed the baseline measure and the first interim measure (after the third program), in accordance with the original design. The second interim measure (originally scheduled for January 18-31, 1975) was delayed until a revised plan could be worked out. By collapsing across various subsamples and interim measures in the original plan, NORC increased the sample size of a posttest for Season A, with remaining resources devoted to a post-only analysis of programs 2-7 in Season B. The revised NORC design (see table) was implemented thus: Wave I, the preseries baseline measure, consisted of a screening interview plus a 30-minute personal interview; Wave II, a Season A interim measure, consisted of 15-minute interviews, about 85% of which were conducted by telephone, the remaining 15% in person; Wave III, designed to serve as much as possible as a Season A posttest, consisted of 15-minute interviews (85% telephone, 15% in person); Wave IV, the final posttest administered after program 7 in Season B, consisted of 30-minute interviews (again, 85% by telephone, 15% in person).

The revisions of the NORC field experiment were influenced by several considerations:

1) As with the RAC study, there was a need to obtain some interpretable data on all 11 Season A programs without jeopardizing the interpretability of Season B data, hence the beefed-up sample size for the Season A posttest. There were additional considerations. At the time of the decision to do the Season A posttest, it was not certain that the NORC field experiment could be continued through Season B at all. NORC required considerable lead time for instrument preparation and pretesting, but the precise content and scheduling of Season B programs were not known at the time. (As it turned out, some of the Season B programs were completed only a few days before air date.) A supplementary check on actual

NORC FINAL DESIGN

	A				B			C	
Treatment Group:	INDUCED TO VIEW AND BE INTERVIEWED (N = 237)				INDUCED ONLY TO BE INTERVIEWED (N = 135)			NO INDUCEMENT (N = 96)	
Treatment Procedure:	$50 payment to view programs A1-11 & B2-7, plus interview cooperation.				$20 payment for interview coop.; no mention of FEELING GOOD.			No payment. No mention of FEELING GOOD.	
Subsample:	1	2	3	4	1	2	3	1	2
WAVE I Preseries Baseline 10/25-11/19/74	130	31	90	-	32	94	-	91	-
WAVE II Season A Interim 12/7-12/20/74	129	-	-	-	32	-	-	-	-
WAVE III Season A Posttest 2/6-2/24/75	120	31	-	28	32	-	23	84	24
WAVE IV Season B Posttest 5/22-6/16/75	116	31	78	26	27	85	23	78	20
Interviewed in all applicable waves	109	29	74	25	27	85	23	76	20

viewing among the induced-viewing group in Season A had indicated that the effectiveness of the inducement procedure was disappointingly low: about half of the induced respondents had been viewing about half the programs. Unless a more effective inducement procedure could be implemented for Season B, there was reason to question whether the data would be interpretable. With the continuation through Season B uncertain, a minimum requirement was to obtain a substantial readout on Season A.

2) The NORC study could not incorporate all of Season B, which was to extend well beyond the time encompassed by NORC's 26-week "viewing contract" with the induced viewers. This agreement had been established prior to Season A, and was considered binding.

3) The NORC study could not incorporate a Season B pretest, due to insufficient lead time, but could implement a post-only analysis on a portion of the Season B programs. (Ultimately all NORC analyses were post-only comparisons among treatment groups.) So that the RAC and NORC studies could cover similar portions of Season B, the decision was made to cover programs B2-B7, and NORC intensified their efforts to encourage viewing among the induced-viewer group.

NORC had to take into account not only the midseries design revisions, but also the actual data distributions obtained on viewing patterns. Post-series examination of these distributions indicated troublesome deviations from expectation: in NORC's view, too many induced viewers had not viewed the series, and too many control group respondents in treatment groups B and C had viewed, to proceed as planned with simple comparisons among the three treatment conditions. Indications of the problem were evident in distributions on four kinds of questionnaire items:

1) On the Season A posttest, and again on the Season B posttest, induced viewers were asked to estimate the total number of Season A programs viewed (all 11, most, about half, only a few, saw but don't remember how many, and none).

2) Week-by-week self-reports on viewing Season B programs were obtained from induced viewers in a mid-B viewing survey (programs B2-B4) and in the Season B posttest (programs B5-B7).

3) For induced viewers, each program (Seasons A and B) had a relevant multiple choice knowledge item (1 correct option, 2 incorrect options; plus "don't know" and "didn't see that show".) Distributions on the "didn't see that show" option provide an index of nonviewing. Distributions on the correct knowledge item option provide a stringent and conservative estimate of viewing.

4) Some estimates of viewing and nonviewing among control respondents (Treatment Groups B and C) is provided by "yes-no" responses to the question "Have you watched FEELING GOOD?" (imbedded in other viewing measures), administered after Seasons A and B.

Summary data from these four items are presented in Table 1.

Given these estimates of viewing patterns, NORC considered an alternative analysis strategy: eliminating all respondents not reporting expected viewing patterns. This would require assurances that possible biases introduced by such a nonrandom reclassification were inoperative or tolerable, as well as requiring decision rules on whose viewing behavior did or did not fall within the original treatment group assignment. NORC reasoned that if these problems could be worked out, it would be a more powerful analysis strategy to retain, rather than eliminate, "deviant" viewers and nonviewers by taking into account levels of viewing and nonviewing within the three original treatment groups. This latter alternative was the one pursued.

The decision to reclassify respondents by viewing levels required an appropriate set of viewing indices and decision rules. Guidance was derived from the basic analytic objectives of the study--to assess effects of:

1) Season A (multiple topics per show; behaviorally oriented);

2) each of the six Season B programs separately (single topic per show; cognitively oriented); and

3) the combination of Seasons A and B.

TABLE 1. NORC STUDY: VARIOUS ESTIMATES OF VIEWING AND NONVIEWING IN TREATMENT GROUPS, SEASONS A & B

	Self-Reports of Viewing	Nonviewing Reported in Responses to Knowledge Items	Correct Option Chosen in Program-Specific Knowledge Items
Group A Induced viewers SEASON A (11 Programs)	In 2 separate waves, (N = 163 - 237) 46% reported viewing most or all of the 11 Season A programs; 54% reported viewing half or less.	Across 11 show-specific knowledge items (N = 109-163) an average of 37% chose the "didn't see that show" option.	Across 11 show-specific knowledge items (N = 109-163) an average of 37% chose the correct option.
Group A Induced viewers SEASON B (6 programs)	Across 6 date-specific questions (N = 237), an average of 64% reported viewing the Season B program aired that week.	Across 6 show-specific knowledge items (N = 237), an average of 25% chose the "didn't see that show" option.	Across 6 show-specific knowledge items (N = 237) an average of 25% chose the correct option.
Groups B & C Induced and non-induced nonviewers SEASON A (11 programs)	A total of 10% reported some viewing of F.G. in Season A; 88% reported no viewing (N = 146).		
Groups B & C Induced and non-induced nonviewers SEASON B (6 programs)	A total of 19% reported some viewing of F.G. in Season B; 80% reported no viewing (N = 231).		

These objectives implied eight separate analysis models or structures to be drawn from the NORC data pool (one for Season A, six for Season B, and one for A + B). All eight models needed appropriate viewing indices across all three treatment groups, so that respondents could be reclassified into viewing subgroups. The definitions of six different viewing indices were required to do this, as described below and in subsequent discussion.

	Group A: Induced to View		Groups B and C: Not Induced to View	
Season A	(1) High Viewer	Low Viewer	(4) Viewed Some	Nonviewer
Season B	(2) Viewer	Nonviewer	(5) Uncertain	Nonviewer
Overall (A + B)	(3) High Viewer	Low Viewer	(6) Viewed Some	Nonviewer

After discussion of alternatives and examination of various data distributions, NORC established the following index definitions (referenced by number to the model above):

1) A stringent criterion was employed: correct responses to program-specific, multiple-choice knowledge items. Wave II (a Season A interim measure) covered programs A1-A3, but used less than half of the induced viewer respondents. Wave III, the Season A posttest, used a majority of the induced viewer respondents, and asked knowledge items on programs A4-A11. Using Wave III data, a "High Viewer" was defined as a respondent getting four or more of these eight knowledge items correct. A "Low Viewer" was defined as one getting 0-3 items correct.

2) Research over Season B covered only 6 programs: B2-B7. Each show covered one major topic, so analyses were run separately for each show. For any one of the six shows, a "Viewer" was defined as a respondent answering the knowledge item for that show correctly (administered in Wave IV, the Season B posttest). A "Nonviewer" was defined as anyone not answering correctly the show-specific question.

3) For the index of viewing on Seasons A and B combined, show-specific knowledge item responses were combined for the Season B posttest, the Seasons A posttest, and, where applicable, the Season A interim measure. A

Table 2. NORC ANALYSIS MODELS, DISPLAYED BY REVISED DESIGN TREATMENT GROUPS AND BY PERCENTAGES WITHIN VARIOUS VIEWING LEVELS

Treatment Group:	Treatment Group A Induced to View and be Interviewed				Treatment Group B Induced to be Interviewed			Treatment Group C No Inducement	
Subsample:	1	2	3	4	1	2	3	1	2
Base N (100%):	(109)	(29)	(74)	(25)	(27)	(85)	(24)	(76)	(20)
SEASON A MODEL									
Viewing Category									
High Viewer	42	35	-	40					
Low Viewer	58	66	-	60					
Viewed Some					11	-	4	15	0
Nonviewer					89	-	96	85	100
SEASON B MODELS									
Viewing Category					Programs B2-B7				
Uncertain Viewer					26	25	17	13	10
Nonviewer					74	75	83	87	90
Viewer (Prg. B2)	28	35	35	44					
B2 Nonviewer	72	65	65	56					
B3 Viewer	18	14	26	20					
B3 Nonviewer	82	86	74	80					
B4 Viewer	18	21	22	32					
B4 Nonviewer	82	79	78	68					
B5 Viewer	42	41	34	32					
B5 Nonviewer	58	59	66	68					
B6 Viewer	24	31	31	20					
B6 Nonviewer	76	69	69	80					
B7 Viewer	6	7	12	8					
B7 Nonviewer	94	93	88	92					
OVERALL MODEL (A+B)									
Viewing Category									
High Viewer	45	48	-	52					
Low Viewer	55	52	-	48					
Viewed Some					37	25	17	21	10
Nonviewer					63	75	83	79	90

"High Viewer" was defined by answering correctly six or more of the knowledge items from Seasons A and B combined. A "Low Viewer" was defined by correct responses to 0-5 knowledge items from Seasons A and B combined.

4) Anticipating minimal viewing within Nonviewer treatment groups B and C, minimal measurement of viewing was made. Imbedded in a series of viewing questions was the item: "Have you watched FEELING GOOD (within the time period specified)?" In Season A, a respondent answering "yes" was classified "Viewed Some"; a respondent not answering "yes" was classified as a "Nonviewer".

5) Season B analyses were run program by program, and viewing data from treatment groups B and C were gathered only at the Season B posttest. Respondents from treatment groups B and/or C reporting some Season B viewing of FEELING GOOD might or might not have viewed the specific program being analyzed, and were therefore classified as "Uncertain Viewers"; all others were classified as "Nonviewers".

6) The Overall (Seasons A + B) Viewing Index for respondents in treatment groups B and C was based on the Season B posttest and/or the Season A posttest and/or the Season A interim measure. Viewing reported in any of these waves classified a respondent as "Viewed Some"; otherwise, she was classified as a "Nonviewer".

Employing the viewing indices above within the framework of the eight analysis models needed, which, in turn, are incorporated in the Revised Design, the total distribution of viewing groups and subgroups within original treatment groups is displayed in Table 2.

The NORC report devotes a chapter of more than 80 pages to the viewing indices summarized above--their rationale, development, and possible undesired qualities and consequences. Much of this was necessitated by the decision to use posterior-defined treatment subgroups (viewing levels) within the original design categories, and the decision to use show specific knowlege items, when possible, as the major viewing index. It was reasoned that self-reports of viewing among induced viewers were possibly inflated, because of the respondents' a priori agreement to view the series. The show-specific knowledge items were more stringent and conservative as a viewing index, probably erring on the side of not counting as many viewers as there really were, and placing these "unregistered" viewers in the nonviewer category, where any series effects would serve to lessen differences between that group and those registered as viewers. General problems inherent in the use of multiple-choice knowledge items were explored in detail, as were some potential nontreatment, nonmeasurement biases resulting from the use of posterior-defined treatment groups. Of necessity, the NORC exposition must be greatly abbreviated here, and the reader with special interest in technical details of the study is referred to the complete NORC study. Some of the major items covered by NORC include the following:

1) Guessing effects (a potential problem with multiple-choice knowledge items). NORC examined the distributions of Season B induced respondents who said in self-reports that they had not seen a program, and who nevertheless chose one of the content options on a separate knowledge item for the same program. Of 31% falling in this category (summed over Season B), 7% gave "correct" knowledge responses (assumedly guessed), and 24% gave incorrect responses (assumedly guessed also). This approximates a chance expectation distribution, and NORC concluded that the probability of misclassifying a respondent as a viewer because of guessing the correct option, at least on Season B, was probably less than 10%.

2) Variation in item difficulty (a potential problem with multiple-choice knowledge items). NORC compared the ratios of percentages correct to percentages incorrect on the knowledge items across all 17 programs (Seasons A and B), concluding that Season B knowledge items (by this measure) were considerably more difficult than Season A knowledge items. The ratio was independent of the proportion reporting not seeing the program at all.

3) Memory effects, or forgetting in the interim between the program and the follow-up interview (a problem applicable to the use of knowledge items). By cross-tabulating percentages correct on knowledge items by amount of lag time between program and interview,

NORC found some evidence of memory effects, with the most discriminating lag time being less than or more than 35 days.

4) Ambiguity about the correct response option (a potential problem with multiple-choice knowledge items). Examination of the knowledge items themselves, in relationship to difficulty ratios (described in item 2 above) suggested that the knowledge item for program B7 had a particularly ambiguous "correct" option.

5) Partial viewing (where a respondent might have seen most of the program, but not the exact part needed to answer the knowledge item). A Season A posttest item asked for the typical amount of viewing within Season A programs (completely, most, about half, less than that, don't know). By cross-tabulating this distribution with correct and incorrect knowledge item responses, NORC found suggestive evidence that those who reported partial viewing were indeed more likely to be determined "nonviewers" on the knowledge item index.

The following quotation summarizes NORC's assessment of the problems in using knowledge items as viewing indices:

> "In conclusion, there are five problems with the use of the knowledge items as indicators of viewing that increase the likelihood of measurement errors, which in turn result in the misclassification of respondents to viewing groups. Guessing effects increase the probability of assigning "Viewer" scores to nonviewers, whereas the other four problems increase the probability of assigning "Nonviewer" scores to viewers. The cumulative influence of these problems on the interpretation of the responses to the knowledge items is that they enhance the conservative character of the decision rule that assigns "Viewer" scores only to persons who gave correct answers. Thus, we can have a high degree of confidence that those women who gave correct responses to the knowledge items did view the programs; however, some of the actual viewers were undoubtedly assigned "Nonviewer" scores." (NORC Report, pp. 73, 75)

In addition to the measurement issues mentioned above, NORC examined several possible "non-treatment effects," all of which could be potential sources of bias in the interpretation of findings regarding program impact:

1) Possible compositional differences across treatment groups. For example, if the viewers have a significantly greater amount of education than the nonviewers, it is possible that the differential impact of the series could be attributable to this educational gradient rather than to the viewing experiences.

NORC displayed six demographic characteristics across the original (randomly assigned) three treatment groups and nine treatment subgroups (NORC, Table 2.26, p. 88), finding them "remarkably similar," indicating that the *a priori* randomization had been effective. NORC then examined how well this comparability extended into the posterior-defined treatment subgroups (levels of viewing). After examining 288 comparisons (6 demographic variables x 3 original treatment groups x 2 levels of viewing x 8 different analysis models), NORC concluded:

> ". . . fortunately, there are no substantial differences in the univariate distributions of demographic characteristics among the viewing groups. Consequently, we do not have to consider the effects of composition differences in the interpretation of the impact of FEELING GOOD." (p. 89)

2) Possible nonrandom attrition. Respondents who didn't have usable data on all applicable interview waves throughout the study form the "attrition sample", which turned out to be about 14% of the total--less than the expected 20%. Selective or uneven attrition could affect the interpretation of series impact on those remaining, but NORC analysts, after comparing both original and posterior-defined treatment group distributions, concluded that:

> ". . . attrition in this study appears to be essentially random, and . . . the exclusion of the 75 respondents in the attrition sample from the analysis of the outcome measures does not affect the interpretation of the impact of FEELING GOOD." (p. 92)

3) Selection bias. This potential problem is the common tendency of persons with high interest and/or knowledge about a topic to view TV programming on that topic in higher proportions than those with lower interest and/or knowledge. The *a priori* control against selection bias was random assignment to treatment groups, but there was a possibility that the posterior-defined groups would reflect preseries differences in interest and/or knowledge about health. Comparisons within and across treatment groups were made with three sets of measures:

(a) an 11-item health history cluster. applying to the pre-FEELING GOOD period; (b) the same 11 items, referring to recent health history during the series; and (c) a 9-item cluster of baseline items dealing with preseries general interest in health topics. Self-selection was not evident in the first two sets of measures, but was in the third: Season B nonviewers were consistently lower in these nine interest measures than were Season B viewers, Season A High Viewers, and Seasons A plus B High Viewers.

4) Baseline differences. The issue here is whether or not inter- and intra-group profiles were similar on substantive measures, such as typical health behaviors. In over 250 comparisons of 88 baseline measures, six significant baseline differences were found, and NORC concluded:

> "These results imply, then, that the presence of some baseline differences may affect the interpretation of the impact of FEELING GOOD on a few specific variables, but, in general, there appears to be no substantial evidence of systematic baseline differences in the measured variables among the viewing groups." (p. 96)

NORC summarizes its examination of possible nontreatment effects thus:

> "In summary, the influence of nontreatment effects appears, fortunately, to be minimal. The analysis of measured characteristics and attributes indicates that there are no systematic composition differences, that attrition was basically random, and that only a few baseline differences are detectable among the viewing groups. The variation in viewing levels within and between the groups did show some association with pre-treatment health interest, but overall we are unable to explain a major portion of the variation in viewing in terms of variables that are typically used to assess selection bias." (pp. 96-97)

A brief summary of NORC data analysis procedures follows. Two comparison groups were deleted from some analyses (see Table 2): (a) the Season A model did not utilize the "Viewed Some" respondents in treatment groups B and C because the N's were considered too small (15 respondents total); (b) Season B models did not utilize the "Uncertain Viewer" respondents from treatment groups B and C because there was no means of determining whether or not viewing had taken place for the particular program being analyzed.

All statistical tests were for significance of difference between two proportions, using significance levels of .05, .01, and .001, one-tailed tests. The arrangement and interpretation of statistical contrasts are summarized separately for each of the three types of analysis models:

1) Season A Model (analyzing Season A's 11 programs collectively). Two contrasts were tested for statistical significance: (a) Treatment Group A "High Viewers" vs. Treatment Group A "Low Viewers"; and (b) Treatment Group A "High Viewers" vs. Treatment Group B "Nonviewers". The NORC interpretation of two significant differences was "strong evidence of an effect"; one significant difference was "weak evidence"; and no significant differences meant "no evidence" of an effect.

2) Season B Models (analyzing separately six Season B programs) employed two contrasts: (a) Treatment Group A "Viewers" vs. "Nonviewers"; and (b) Treatment Group A "Viewers" vs. Treatment Group B "Nonviewers". As with the Season A model, the NORC interpretation of zero, one, or two significant differences was, respectively, "no evidence", "weak evidence", and "strong evidence" of viewing effect.

3) Overall (Seasons A plus B) Model employed both of the contrasts listed in the Season A model above, plus, when computable, these additional contrasts: (a) Treatment Group B "Viewed Some" vs. Treatment Group B "Nonviewers"; and (b) Treatment Group C "Viewed Some" vs. Treatment Group C "Nonviewers". NORC interpretation rules differed, depending on whether a total of three or four contrasts were computable. If 4, then "strong evidence" consisted of three or four significant differences; "weak evidence" was one or two significant differences; and "no evidence" meant zero significant differences. If only three contrasts were computable, then "strong evidence" meant two or three significant differences; "weak evidence" meant one significant difference, and "no evidence" meant zero significant differences.

Demographic Profiles of Respondents in Four Studies

This section presents demographic profiles of respondents in RAC's Four-City study, NORC's Induced Viewing study, Gallup's four national surveys, and Nielsen's national ratings sample.

Table 3 displays proportional distributions for sex, age, education level, and homes having children under six for nine separate waves within the RAC study. In four of these waves, respondents are also subdivided by viewing levels: these data show little compositional difference across viewing levels on these four variables. The additional variable of race/ethnicity is displayed in Table 4 for the RAC postseries respondents (both pretested and unpretested); these data show predominantly (89-92%) white respondents among the voluntary viewers, 4-7% black, and 1% Spanish/Mexican American.

In the Appendices of the NORC study, the demographic distributions of respondents are displayed separately for each of eight analysis models: one for Season A, one each for six Season B shows, and one for a Season A plus B analysis. Two illustrative tables drawn from the NORC Appendices are presented here:

1) Table 5 (Season A model). Here a Treatment Group A "High Viewer" was defined by getting four or more show-specific knowledge items correct over shows A4-A11. A "Low Viewer" was defined as 0-3 knowledge items correct. (All definitions are reviewed earlier in this chapter.)

2) Table 6 (Season B model, Program B-5). This program, on the topic of breast cancer, had the highest viewership among programs B2-B7, as indexed by show-specific knowledge items. Treatment Group A "Viewers" were defined simply as those getting the B-5 knowledge item correct; others were called "nonviewers".

Again, the profiles in general are quite similar across treatment groups and across six demographic variables.

Distributions across six demographic variables are displayed for each of the four Gallup national surveys in Table 7. The demographic makeup of all four surveys is quite similar.

Finally, demographic characteristics of the Nielsen national ratings sample are displayed in Table 8.

Table 3. COMPOSITE DEMOGRAPHIC PROFILES IN THE FOUR-CITY STUDY (RAC)

	Sex		Age			Education			Children	Base N:
	M	F	18-34	35-54	55 +	Coll.	HS Grad	< HS Grad	under 6	weighted (unweighted)
1. Screening Survey	50	50	46	[53%]		45	46	6	21	22,120 (22,120)
2. Season A - November Baseline	38	60	44	34	20	48	47	4	24	13,492 (5063)
Later viewing levels:										
A. Frequent viewers	33	67	44	34	21	49	36	14	25	
B. Less frequent viewers	36	64	42	37	21	51	35	14	22	
C. Nonviewers	39	61	39	36	25	50	37	14	20	
3. Interim Measure #1 (all respondents)	38	62	44	33	22	51	36	12	25	1401 (518)
A. Viewed some of A1-A4 (Q 17 yes)	30	69	45	35	17	63	31	6	37	248
B. No viewing of A1-A4 (Q 17 no)	40	60	45	32	22	49	37	13	23	1138
4. Interim Measure #2 (all respondents)	38	61	41	36	22	51	36	12	24	1272 (466)
A. Viewed some of A5-A8 (Q 19 yes)	35	64	49	36	16	53	36	10	24	301
B. No viewing of A5-A8 (Q 19 no)	39	60	39	36	24	50	37	13	24	969

Table 3. (Cont'd.) COMPOSITE DEMOGRAPHIC PROFILES IN THE FOUR-CITY STUDY (RAC)

	Sex		Age			Education			Children	Base N:
	M	F	18-34	35-54	55+	Coll.	HS Grad	< HS Grad	under 6	weighted (unweighted)
5. Interim Measure #3 (All pretested respondents)	40	59	41	34	23	50	35	15	19	1121 (411)
A. Viewed some of A9-All (Q 12 yes)	41	55	40	32	27	52	30	17	21	282
B. No viewing of A9-All (Q 12 no)	39	60	41	35	22	50	36	14	19	838
6. Interim Measure #3 (all control [unpretested] respondents)	39	60	42	37	18	51	45	4	23	678
A. Viewed some of A9-All (Q 12 yes)	46	53	45	30	21	47	48	4	16	181
B. No viewing of A9-All (Q 12 no)	37	63	41	40	18	52	44	4	25	495
7. Season B Posttest	37	63	41	36	23	50	37	13	10	9777 (3705)
8. Unpretested Panel Control Group - Season B Posttest	39	61	40	38	22	50	34	16	21	2101 (1066)

Table 4. RACE/ETHNICITY DISTRIBUTIONS IN THE FOUR-CITY STUDY (RAC): POST-SERIES DATA FROM PRETESTED AND UNPRETESTED RESPONDENTS

	Pretested		Not Pretested	
	unweighted base N = 3705 weighted base N = 9777		unweighted base N = 1066 weighted base N = 2101	
	weighted subgroup size	Percent of weighted Base N	weighted subgroup size	Percent of weighted Base N
White/Caucasian	(8960)	92	(1869)	89
Black/Negro/Afro-American	(363)	4	(148)	7
American Indian	(28)	*	(7)	*
Spanish-American/Mexican-American	(76)	1	(16)	1
Puerto Rican	(5)	*	(2)	*
Oriental	(29)	*	(13)	1
None of these	(45)	*	(10)	*
Prefer not to answer	(270)	3	(36)	2

*less than 1%

Table 5. DEMOGRAPHIC CHARACTERISTICS FOR SEASON A VIEWING GROUPS, NORC STUDY

Demographic Characteristics	A Hi Viewer	A Lo Viewer	B Non-Viewer	C Non-Viewer	B Viewed Some	C Viewed Some
Race:						
Spanish surname	8	16	11	8	0	36
Black	42	40	49	41	50	27
White	50	43	40	48	50	36
Other	0	0	0	2	0	0
Annual Household Income:						
Under $6,000	30	36	26	30	0	0
$6,000-$9,999	15	22	11	17	25	18
$10,100 or more	50	32	52	44	50	73
Don't know, refused						
Age:						
18-34	45	46	29	39	50	82
35-54	31	28	13	27	25	18
55 or more	9	10	9	10	0	0
Missing	15	16	49	24	25	0
Education:						
8th grade or less	14	23	4	13	0	0
High School, incomplete (grades 9, 10, 11)	18	26	36	28	0	27
High School, complete (12th Grade)	40	36	29	45	75	54
College, incomplete	11	9	16	10	25	9
College, complete	17	6	16	4	0	9
Don't know, refused						
Occupation of Household Head:						
Professional, managerial	20	25	26	22	50	18
Sales, clerical	16	16	21	11	0	27
Craftsman operatives	38	41	42	39	50	27
Laborers, service workers	27	16	12	25	0	27
Farm	0	0	0	1	0	0
Don't know, refused	0	1	0	1	0	0
Child(ren) under 6 years old:						
yes	52	54	61	52	75	64
N	(66)	(97)	(46)	(85)	(4)	(11)

Table 6. DEMOGRAPHIC CHARACTERISTICS FOR PROGRAM B-5 VIEWING GROUPS, NORC STUDY

Demographic Characteristics	A Viewer	A Non-Viewer	B Non-Viewer	C Non-Viewer	B Uncertain Viewer	C Uncertain Viewer
Race:						
Spanish surname	17	12	11	10	6	25
Black	47	36	42	39	41	42
White	36	51	47	49	53	33
Other	0	0	0	2	0	0
Annual Household Income:						
Under $6,000	28	32	21	27	16	25
$6,000-$9,999	24	19	19	17	16	17
$10,000 or more	44	40	50	47	56	50
Don't know, refused	4	10	9	9	12	8
Age:						
18-34	50	45	49	42	55	58
35-54	30	30	21	28	19	17
55 or more	11	11	12	8	13	8
Missing	9	14	19	22	13	17
Education:						
8th grade or less	21	16	12	14	6	0
High School, incomplete (grades 9,10,11)	13	30	30	26	39	42
High School, complete (12th grade)	43	32	36	48	32	33
College, incomplete	10	11	10	7	19	17
College, complete	13	10	12	4	3	8
Don't know, refused						
Occupation of Household Head:						
Professional, managerial	24	22	25	20	30	25
Sales, clerical	12	17	16	13	20	17
Craftsman operatives	41	38	43	37	37	42
Laborers, service workers	17	19	17	27	13	17
Farm	2	0	0	1	0	0
Don't know, refused						
Child(ren) under 6 years old:						
Yes	55	52	59	52	53	58
N	(91)	(146)	(103)	(84)	(32)	(12)

Table 7. DEMOGRAPHIC PROFILES FOR THE NATIONAL SURVEYS (GALLUP)

Survey Number:	1	2	3	4
Field Dates:	12/3-8/74	2/1-3/75	4/18-21/75	5/30-6/1/75
Sample Size:	(1,517)	(1,544)	(1,599)	(1,626)
	%	%	%	%
SEX:				
male	47	48	48	48
female	53	52	52	52
AGE:				
18-34	37	37	36	37
35-49	26	25	24	24
50 and over	37	37	39	38
EDUCATION:				
college	25	25	25	25
high school	55	54	55	56
grade school	19	20	20	18
RACE:				
white	88	86	82	85
black	11	13	15	14
other	2	2	2	1
SIZE OF COMMUNITY:				
1,000,000 + (inc. urban fringe)	16	17	18	18
250,000-999,999 (inc. urban fringe)	20	22	20	22
50,000-249,999 (inc. urban fringe)	19	19	17	18
2,500-49,999 (inc. urban fringe)	16	17	17	16
under 2,500	28	25	27	26
ANNUAL FAMILY INCOME:				
$15,000 and over	28	30	32	32
$10,000 - $14,999	24	25	24	24
$5,000 - $9,999	26	25	23	25
under $5,000	20	18	20	18
undesignated	2	2	1	2

Table 8. DEMOGRAPHIC PROFILES FOR THE NIELSEN NATIONAL RATINGS SAMPLE

NIELSEN TELEVISION INDEX: AVERAGE DAILY SAMPLE SIZE BY MARKET SECTIONS

(4 weeks ending 12/22/74)

	No. of Households	%	% TV Households (U.S. Census estimates) %
Composite	1002	100.0	100.0
County size			
A	417	41.6	40
B	285	28.4	28
C & D	300	30.0	32
Color TV ownership			
Color	678	67.7	68
Black & white only	324	32.3	32
Presence of nonadults in household			
None under 18	518	51.7	55
Any under 18	484	48.3	45
Any under 12	350	34.9	34
Any under 6	200	19.9	21
Any under 3	110	11.0	12
Any aged 6-11	240	24.0	22
Any aged 12-17	264	26.3	23
Household income			
Under $10,000	424	42.3	47
$10,000 - $14,999	266	26.5	23
$15,000 and over	312	31.2	30
$20,000 and over	156	15.6	14
Lady of house			
18-34 years	279	27.8	30
35-54 years	384	38.3	33
55 years and over	265	26.4	29
Household size			
1-2	462	46.1	49
3-4	347	34.6	33
5 or more	193	19.3	18
Number of nonadults in household			
1	179	17.9	16
2 or more	305	30.4	29
Education of head of house			
0-8 years grade school	155	15.5	22
1-3 years high school	159	15.9	16
4 years high school	342	34.1	33
1 or more years college	346	34.5	29
4 or more years college	187	18.7	16

CHAPTER THREE: MEDIA ISSUES

The summative evaluation program described in Chapter Two generated a large body of data with implications for goal-directed broadcasting, health education, and evaluation of social action programs. While a series such as FEELING GOOD must operate as a system that spans all these areas, it is useful to discuss the findings separately:

- Goal-directed broadcasting. Chapter Three summarizes data concerning some media-system factors which affected the potential impact of the series--such as program availability, public awareness of the series, size and characteristics of the viewing audience, and amount of repeat viewing.
- Health education. The largest part of the data, dealing with the effects of programs on viewers' knowledge and behavior regarding various health topics, is reported in Chapter Four.
- Evaluation of social action programs. A number of evaluation issues, including some unique to this series and several of a more general nature, are examined in Chapter Five.

- Finally, opportunities for extending the utility of the data through additional analyses and new research are described in Chapter Six, and some important media issues not covered by the evaluation are discussed.

Systemic and Situational Constraints

There are several prerequisite conditions for demonstrably affecting health knowledge and behavior by means of a goal-directed television series distributed in prime time on PBS. First, the PBS signal must be available. It is generally estimated that around 80% of the U.S. population lies within the predicted Grade B contour of a public television station. Within this contour, however, there is considerable variation in actual reception quality; it is reasonable to assume, as an additional prerequisite, that there must be good PBS reception at the individual household level.

Moving from "objective reality" to "subjective reality", it is relevant to know how many people within PBS signal areas who get good reception at home are aware that PBS programming is available. It is relevant to know whether the fact that a program is on public television increases or decreases the likelihood of viewing (or at least sampling) the program. Pre-series self-assessments of probable interest in viewing programs on health are relevant to some extent (i.e., generalized predispositions toward the programming concept). The availability of an individual to view at the proposed broadcast time is clearly a prerequisite, as is the lack of a pre-series commitment to viewing alternative programs being broadcast at the same time as the proposed series. The potential audience member must then be aware that the new program is available; this is largely a function of promotion to stimulate trial viewing. Given trial viewing, the programs must be perceived as being more attractive than alternative programming available by a simple turn of the dial. For some portion of the audience now viewing the FEELING GOOD programs, continuing hypothetically, the information or advocated behaviors will either be inapplicable (in reality or as perceived) or will be already known (or practiced). For others, it is probable that relevant goal-directed learning or persuasion will occur, but will be overcome by forgetting or some situational inability to follow through. For others, it is reasonable to expect some informational or behavioral impact of the series.

Some of the constraints above are specific to FEELING GOOD, but many of them are general features of the technological/sociological system in which all goal-directed television programming for the voluntary audience must operate. Various data from the Gallup Surveys, the RAC four-city study, and the NORC study provide estimates on some of these systemic and situational constraints, and are summarized here.

Awareness and Viewing of Public Television. In four cities served by strong, promotionally-active public stations operating on VHF, how many adults could identify the channel number of the public television station? An item in RAC's screening interviews in Boston, Dallas, Seattle, and Jacksonville, (Fla) asked for the public station's channel number. In 22,120 interviews 83% could identify the channel number correctly. Of the 17% overall who could not correctly identify the channel number, many were in the low education group:

8th grade or less: 43% (100% = 1,251)
some HS or HS grad: 19% (100% = 10,666)
some college or college grad: 10% (100% = 9,959)

Nationally, what proportions of the population met the dual criteria of (1) knowing that PBS programming was available in their area, and (2) knowing that they could get good reception of the PBS signal? Conversely, what proportions didn't know whether or not PBS programming was available to them? How did educational subgroups differ on these two questions? Four national surveys by Gallup provide relevant data, displayed in Table 9.

The NORC respondents represented a target audience of particular interest to the FEELING GOOD experiment--minority and low-income, low-education groups. Several methodological trade-offs were accepted in order to assess this population. Their general television-viewing habits are relevant to the

Table 9. SELF-REPORTS OF PBS RECEPTION BY EDUCATION SUBGROUPS: FOUR NATIONAL SURVEYS (GALLUP)

Gallup Survey #:	1	2	3	4
Get good PBS reception				
Overall, base N:	(1517)	(1544)	(1599)	(1626)
%:	38	36	40	40
College, base N:	(491)	(479)	(480)	(498)
%:	50	52	53	52
High School, base N:	(816)	(828)	(897)	(902)
%:	40	35	42	39
Grade School, base N:	(202)	(231)	(218)	(219)
%:	20	20	19	26
Don't know if PBS available or not				
Overall, base N:	(1517)	(1544)	*	(1626)
%:	22	26		25
College, base N:	(491)	(479)	*	(498)
%:	15	16		20
High School, base N:	(816)	(828)	*	(902)
%:	22	25		23
Grade School, base N:	(202)	(231)	*	(219)
%:	32	42		39

* Not reported

consideration not only of the FEELING GOOD experiment, but also to general media strategy issues in future programming on health or other social problems.

NORC preseries baseline measures (N = 400) demonstrate the high level of television viewing in general for this population, as well as the present limitations of public broadcasting and educational purposive programming:

1) 85% view television nearly every weekday;

2) 51% view 20 or more hours per week, excluding weekends; another 31% view between six and 19 hours per week, excluding weekends;

3) 41% have two or more TV sets in good working order;

4) Insight into the status of educational or purposive programming in the normal viewing habits of the NORC population can be gleaned from the types of programming reportedly avoided (watched "hardly ever" or "never"). Item: When you turn on television, how often do you watch . . .

	% "hardly ever" or "never"
a. a program that teaches about how to do things, like cooking, taking care of plants, how to take care of you and your family's health, or exercise:	44
b. an entertainment program:	11
c. a news program	5

5) As a source of most of the viewing for the NORC population, the VHF public television station, KERA, tied with a UHF station for last place. Item: When you watch television, which channel do you watch the most?

KDFW, Channel 4 (CBS)	33%
WFAA, Channel 8 (ABC)	28%
KTVT, Channel 11 (Independent)	15%
WBAP, Channel 5 (NBC)	9%
Don't Know	6%
More than one channel	3%
KXTX, Channel 39	3%
KERA, Channel 13	3%

6) Most of the NORC population viewed the public television station infrequently. Item: How much do you watch channel 13?

Never	11%
Once a week or less	41%
Two or three times a week	27%
Nearly every day	20%

Although the NORC results may not be generalizable nationally, this one low-income community viewed an enormous amount of television, but it was mostly for news and entertainment, as opposed to educational programming, and mostly on commercial stations, as opposed to public television.

Attitudes toward Health Series Concept and Public Television. Before the series began, what attitudes or predispositions were evident for and against the FEELING GOOD concept, as well as public television in general? On the positive side, RAC found that two out of three responded favorably to a brief description of the forthcoming health series, saying that the description sounded like the kind of show they would want to watch or at least try once or twice; 28% said they would be *more* likely to watch such a series because it would be offered on public television. On the other hand, 22% reacted negatively to the brief description, saying they probably would *not* watch the upcoming health series, and 28% said they would be less likely to view the series because it was to be on public television. (RAC screening interviews, N = 22,120.)

Audience Availability. What proportion of the audience was already "committed" to regularly viewing one of the three commercial network offerings at 8:00 p.m. Wednesday evenings, or were not available for watching TV at that time? Again, the RAC screening interviews for the four-city study provides some data (N = 22,120): 14% said they could not watch TV on Wednesday evenings at 8:00 p.m.; 52% were already regular viewers of the network "competition" at the time of the study: THAT'S MY MAMA, SONS AND DAUGHTERS, or LITTLE HOUSE ON THE PRAIRIE. (Shortly before CTW's health series went on the air, SONS AND DAUGHTERS was replaced by four weekly specials followed by a new series, TONY ORLANDO AND DAWN.)

Awareness of FEELING GOOD. How many people became aware that FEELING GOOD was on the air? No data on preseries awareness are available, but the Gallup Organization measured awareness of FEELING GOOD (along with five other shows) at four times during the series. National awareness of FEELING GOOD was approximately 22% in the first half of the series, and 33% in the last half. Regardless of its standing vis-a-vis first-year awareness of other PBS adult programming, this means that even by the end of the first broadcast season (Seasons A and B), two out of three adults did not know of the series' existence. Among these same respondents, more than eight out of ten were aware of FEELING GOOD's competition on the three commercial networks. Lack of awareness, therefore, appears to have been a significant problem.

Tables 10 and 11 display for each of the four Gallup surveys the reported awareness and viewing of six national series by levels of education and age. Gallup respondents were given a card containing the names and networks of the six series. Respondents were first asked which series they had heard about (awareness); they were then asked which of the programs they had seen at least once during a preceding period that varied somewhat from survey to survey.

The following observations are based on data in Table 10:

1) College-educated respondents did not differ markedly from high school-educated respondents in level of awareness of FEELING GOOD or the commercial network competition of this series. Both of these education groups were considerably more aware of FEELING GOOD and the network competition than were the grade school-educated respondents.

Table 10. AWARENESS AND VIEWING OF SIX SERIES BY THREE EDUCATION LEVELS, ACROSS FOUR SURVEY INTERVALS (GALLUP)

	Education Level					
	College		High School		Grade School	
	Aware %	View %	Aware %	View %	Aware %	View %
Gallup Survey #1 (12/74); base N:	(491)	(491)	(816)	(816)	(202)	(202)
Feeling Good	27	8	22	7	14	6
Masterpiece Theatre	67	36	47	23	23	12
Kojak	91	71	87	70	73	61
Tony Orlando and Dawn	66	26	66	31	42	14
Little House on the Prairie	76	38	82	54	68	54
That's My Mama	69	36	76	50	61	41
Gallup Survey #2 (2/75); base N:	(479)	(479)	(828)	(828)	(231)	(231)
Feeling Good	29	8	21	5	14	8
Masterpiece Theatre	66	33	40	19	23	11
Kojak	94	62	92	73	69	54
Tony Orlando and Dawn	80	44	82	52	59	41
Little House on the Prairie	85	41	83	55	72	52
That's My Mama	76	38	81	53	66	48
Gallup Survey #3 (4/75); base N:	(480)	(480)	(897)	(897)	(218)	(218)
Feeling Good	40	9	39	10	21	[illegible]
Masterpiece Theatre	67	30	56	19	25	11
Kojak	94	65	94	67	75	55
Tony Orlando and Dawn	86	46	87	56	67	44
Little House on the Prairie	87	41	86	51	69	48
That's My Mama	83	44	86	51	66	43
Gallup Survey #4 (5-6/75); base N:	(498)	(498)	(902)	(902)	(219)	(219)
Feeling Good	41	9	33	9	21	6
Masterpiece Theatre	68	30	53	18	26	11
Kojak	95	62	94	74	74	50
Tony Orlando and Dawn	86	49	89	50	63	37
Little House on the Prairie	90	41	87	57	73	52
That's My Mama	78	39	82	33	69	45

2) Awareness of the three competing commercial network programs (LITTLE HOUSE ON THE PRAIRIE, TONY ORLANDO AND DAWN, THAT'S MY MAMA) tended to be two, three, and even four times higher than awareness of FEELING GOOD.

3) Across time, awareness of FEELING GOOD increased within all three levels of education, with the major increment showing up between Seasons A and B. Across these same time periods, awareness of the established PBS series MASTERPIECE THEATRE remained stable at about two-thirds of the college-educated people and one-fourth of the grade school-educated. Only for high school-educated respondents did awareness of MASTERPIECE THEATRE increase over time.

4) Relative to FEELING GOOD, there was a wider range in levels of awareness of MASTERPIECE THEATRE: clear three-step progressions were evident across the three levels of education for the latter series.

5) About half of all adults were aware of the long-running MASTERPIECE THEATRE, while awareness of FEELING GOOD grew in six months to about one-third of all adults.

6) Although there was some growth in awareness of FEELING GOOD, as indicated in Table 10, there was little corresponding growth in actual viewership.

7) There was far less difference in proportions viewing FEELING GOOD across levels of education than was true for MASTERPIECE THEATRE; i.e., the MASTERPIECE THEATRE audience drew selectively from highly educated subgroups more than FEELING GOOD did.

Table 11 indicates that, in general, young adults 18-34 were the most aware of (i.e., had heard of) all of the mentioned programs, including FEELING GOOD. Also in general, the heaviest viewing was reported by the 18-34 age group, with the smallest differences among age groups occurring for three series: FEELING GOOD, MASTERPIECE THEATRE, and LITTLE HOUSE ON THE PRAIRIE.

The highest level of awareness reached with FEELING GOOD (40%) was with the 18-34 age group, but the highest level of viewing reached (11%) was with the 35-49 age group in Season B.

The problem of awareness of FEELING GOOD was also evident in RAC's four-city study, which systematically oversampled respondents likely to view the series:

Table 11. AWARENESS AND VIEWING OF SIX SERIES BY THREE AGE LEVELS, ACROSS FOUR SURVEY INTERVALS (GALLUP)

	Age					
	18-34 Years		35-49 Years		50 Years and Over	
	Aware	View	Aware	View	Aware	View
	%	%	%	%	%	%
Gallup Survey #1 (12/74); base N:	(566)	(566)	(391)	(391)	(550)	(550)
Feeling Good	27	9	21	6	18	6
Masterpiece Theatre	57	29	46	21	39	22
Kojak	94	76	88	69	75	60
Tony Orlando and Dawn	76	37	66	27	44	16
Little House on the Prairie	82	50	81	49	71	51
That's My Mama	82	55	73	43	59	36
Gallup Survey #2 (2/75); base N:	(567)	(567)	(373)	(373)	(587)	(587)
Feeling Good	26	7	20	6	18	[illegible]
Masterpiece Theatre	52	24	42	21	34	17
Kojak	96	76	91	67	77	56
Tony Orlando and Dawn	93	59	74	46	63	38
Little House on the Prairie	88	52	80	47	76	53
That's My Mama	88	57	75	45	66	42
Gallup Survey #3 (4/75); base N:	(571)	(571)	(374)	(374)	(645)	(645)
Feeling Good	40	9	35	11	32	8
Masterpiece Theatre	59	19	55	22	45	20
Kojak	96	67	94	67	82	60
Tony Orlando and Dawn	90	57	86	50	74	46
Little House on the Prairie	88	44	82	47	80	51
That's My Mama	89	54	84	48	72	42
Gallup Survey #4 (5-6/75); base N:	(555)	(555)	(376)	(376)	(685)	(685)
Feeling Good	40	9	35	11	24	6
Masterpiece Theatre	58	18	52	20	45	22
Kojak	97	73	93	68	82	60
Tony Orlando and Dawn	93	60	84	54	73	46
Little House on the Prairie	91	50	84	55	80	52
That's My Mama	90	55	78	52	69	40

> "More than half of all respondents (53%) reported no viewing of the entire hour-long series or the initial eight half-hour episodes of FEELING GOOD. . . . Over half of these non-viewers say they did not know the show was on the air. (Emphasis in the original.) This rationale was given almost uniformly across demographic subgroups . . . It appears from these findings that the audience potential for FEELING GOOD was unrealized in large part because respondents did not know it was on."

The RAC posttest asked the 1,947 non-viewers in their study to select from a variety of possible reasons for not watching those which applied to them. Results are displayed in Table 12.

Without taking into account the issues of ceiling effects, inapplicability of particular topics to various audience members, or limitations inherent in the general art and science of evaluation processes, the following constraints are evident from the data and discussion above:

1) Good PBS reception is reported by about 40% of the U.S. population, or half of the generally-assumed PBS coverage. Proportionately, the high-education group outnumbered the low-education group two to one in reporting good PBS reception. (It should be noted, however, that self-reported PBS viewing was not restricted to households reporting "good" PBS reception.)

2) Lack of knowledge as to whether PBS programming was or was not available ran about 25% overall. Proportionately, the low-education group outnumbered the high-education group two to one in this lack of knowledge. The low-education group was four times more likely than the high-education group to be unable to specify the local PBS channel number. Both this fact and the one noted above imply a limitation in systemic capacity to reach low-education groups via PBS.

3) More than half of the potential viewers were regularly viewing the network competition programs before the FEELING GOOD series began, and another 14% were unavailable for TV viewing at the time of the Wednesday evening FEELING GOOD broadcasts.

4) Although not a systemic constraint per se, the fact that most people were never aware of FEELING GOOD's existence placed a non-programmatic limitation on the

Table 12. REASONS GIVEN BY SERIES NONVIEWERS FOR NOT VIEWING (RAC POSTTEST)

(Multiple responses permitted)	(N = 1,947) %
1. I didn't know it was on the air:	54
2. I don't watch much TV at all:	32
3. I don't watch the public TV channel:	14
4. I am not at home when it is on:	13
5. I watch a different program at the same time Feeling Good is on:	12
6. The show didn't sound interesting:	5
7. I don't get a good picture on the public TV channel:	3
8. I'm not interested in health things:	2
9. None of these:	8

Table 13. ESTIMATED COST PER FEELING GOOD PROGRAM EXPOSURE

Series Cost = $7,400,000**

Audience Definitions	Cost per Program Exposure
1. Combined Average Audience* adults for Seasons A & B = 25,800,000	29¢
2. Combined Average Audience* adults for Seasons A & B and Summer reruns of B = 40,920,000	18¢
3. Combined Total Audience* adults for Seasons A & B = 41,592,000	18¢
4. Combined Total Audience* adults for Seasons A & B and Summer reruns of B = 59,916,000	12¢

* Figures for combined average audience (audience during average minute of program) and total audience (audience viewing 6 or more minutes of program) are based on Nielsen estimates, and are subject to the methodological and interpretive qualifications cited in the Nielsen report to CTW.

** This figure represents the full cost of the project, covering production, content development, formative and summative research, promotion, and special outreach activities.

reach and impact of the series. Four out of five adults had not heard of the series during Season A; two out of three had not heard of it during Season B.

5) Preseries reaction to the concept of FEELING GOOD was 67% favorable, 22% unfavorable, and 11% uncertain. The translation of this into reactions to the specific FEELING GOOD programming is not precise, but it does describe the attitudinal climate before programming began. It implies that for the 22% "unfavorable", the actual programs would have to overcome a negative bias.

In conclusion, the near-universality of television receivers does not imply a realistic potential for universal reach by any particular program. Successive limitations in the potential for any program or series can be traced through actual and perceived reception ability, predispositions toward the program concept, uncommitted availability of time to view, established habit patterns of viewing or not viewing public television in general, and awareness of particular programs. Nevertheless, because of the tremendous numerical base on which these successive limitations are imposed, the residual audience of "true prospects" is huge in absolute terms, making significant social problems such as health worthwhile for experimentation with purposive television programming, and offering the prospect of cost-effective impact.

In the case of FEELING GOOD, for example, the approximate cost per program exposure can be obtained by dividing the estimated cost of the series by the estimated total number of audience members reached (see Table 13).

The evaluation of the cost figures is subject to multiple interpretations, depending on the set of contextual assumptions employed. For example, if evaluated as a service delivery system as opposed to an experiment, the cost-per-program-exposure figures should be compared to those obtained for alternative means of conveying similar information or alternative means of achieving similar impact. If evaluated as an experiment to generate policy-relevant insights into the use of purposive television for health education, it is then appropriate to look not only at what did result, but also what is a reasonable expectation of results under various other circumstances. To illustrate, the present cost-per-exposure figures are based on voluntary viewing with a national awareness level of only one-third or less. If a significantly increased awareness level would lead to a corresponding increase in audience size, the additional promotional effort could reduce substantially the cost per program exposure. To illustrate, the most conservative estimate of series exposure, Seasons A + B Average Audience, yielded the highest cost-per-exposure estimate of 29¢ (definition 1, Table 13). An additional $1 million in promotional budget would have broken even in these cost-per-exposure terms by attracting an average of only 132,000 new viewers for each of the 24 programs in the series, and any additional viewers would, of course, reduce the cost per exposure, even with the added promotional expense. The intent here is not to make a specific prediction about how many new audience members could be attracted per promotional dollar spent, but to point out that under reasonable assumptions, extensive promotion can be a good investment for goal-directed programming.

Continuing in the speculative vein, one might presume a higher rating (hence lowered costs per exposure) in a less powerful competitive programming environment. Two of the commercial network series running opposite FEELING GOOD were attracting very large audiences: LITTLE HOUSE ON THE PRAIRIE and TONY ORLANDO AND DAWN both ranked among the most popular programs on television during the winter season. FEELING GOOD might have drawn a larger audience on a different night of the week, or in a different time period, but this cannot be stated with certainty.

The data in Table 16 indicate that repeat broadcasts within the week each program was first shown attracted about as many viewers as the original broadcasts, thus reducing the per-exposure cost by half. The added reach of the summer re-run of Season B programs made possible a further reduction, and presumably any subsequent uses of the programs would reduce the per-exposure cost still further.

Of course, exposure is a necessary but not sufficient condition for a motivational program or series to affect viewers' behavior. Measures of exposure rather than of impact are commonly used in estimating the cost-effectiveness of commercial advertising, although the critical figure is the cost per action taken rather than the cost per person reached. Ideally, a comparative assessment of FEELING GOOD and other types of programs (as proposed in Chapter Six) would include estimates of cost per action taken as well as cost per exposure.

Season A and Season B: The Experiment Within an Experiment

The original evaluation plan, of course, did not contemplate the incorporation of two quite different program formats in the experimental broadcast season. As an experimental manipulation, the switch from Season A to Season B does not yield to precise interpretation because many factors or variables were changed simultaneously: program length, the cast, the different times of the year for the broadcasts, the shift in emphasis from behavioral to informational goals, the change from multiple topics to a single topic per program, the decreased emphasis on comedy, and so on.

Furthermore, the available measures or indices that can be used to compare Seasons A and B are quite limited. On measures of informational/attitudinal/behavioral impact, the two seasons are not readily comparable because proportionately more evaluation resources were committed to a smaller number of programs in Season B. This made possible the use of different and more powerful data analysis models in Season B. Both RAC and NORC conclude that the assessments of impact in Season A are conservative, relative to the analyses in Season B, in which it was possible to track show-specific viewing among larger samples across fewer programs.

Size of Audience. One basis for comparing Seasons A and B is the size of the audience attracted. Here there appears to be little difference in the two versions of FEELING GOOD. An averaging of Nielsen estimates of the number of adults in the weekly average audience (based on households viewing during the average program minute) indicates that Season A attracted about 1,152,000 adults per program, while Season B attracted about 986,000 adults per program at a time of year characterized by less overall television viewing. (According to Nielsen, the proportion of households using television at 8:00 p.m. on Wednesdays averaged 64% during Season A, 52% during Season B, and 46% during the Season B rerun.) The per-program estimates of the proportions of adults and households reached with FEELING GOOD are presented in Table 14. Other Nielsen data on Season A, Season B, and the Season B rerun are given in Table 15.

During a six-week period in the 1974-75 winter season, Nielsen also obtained ratings data for other PBS prime-time programs. The average AA rating for all such programs was 1.0. FEELING GOOD ranked in the top third on the basis of AA ratings for the first six programs in the series.

Viewing of Original vs. Repeat Broadcasts. Any purposive program in prime time faces heavy competition from expensively-produced and heavily-promoted programs designed solely to entertain. One virtue of the PBS system is that it permits repeat telecasts of programs at other hours when the competition is less formidable, and a question naturally arises as to how the audience attracted to non-prime time repeat telecasts compares with that obtained for original prime time showings.

Table 14. NATIONAL AUDIENCE ESTIMATES FOR FEELING GOOD, SEASONS A AND B (GALLUP AND NIELSEN)

SEASON A					SEASON B				
Program Number:	Aired week of:	Gallup % all adults (rounded)	Nielsen weekly average audience %	Nielsen weekly total audience %	Program Number:	Aired week of:	Gallup % all adults (rounded)	Nielsen weekly average audience %	Nielsen weekly total audience %
A-1	11/20	3	2.6	4.4	B-1	4/2	2	1.2	1.5
A-2	11/27	2	1.1	2.4	B-2	4/9	2	1.3	1.9
A-3	12/4	3	1.5	3.3	B-3	4/16	2	1.1	1.5
A-4	12/11	2	1.1	2.7	B-4	4/23	1	.9	1.2
A-5	12/18	1	1.2	2.2	B-5	4/30	2	1.3	1.5
A-6	12/25	2	1.0	2.1	B-6	5/7	2	1.9	2.0
A-7	1/1/75	2	1.4	3.0	B-7	5/14	1	.9	1.1
A-8	1/8	2	1.7	3.3	B-8	5/21	1	1.2	1.5
A-9	1/15	1	.8	1.7	B-9	5/28	1	1.1	1.4
A-10	1/22	2	1.0	2.3	B-10	6/4	*	1.1	1.5
A-11	1/29	2	2.1	3.5	B-11	6/11	*	1.4	1.8
					B-12	6/18	*	1.3	1.5
					B 13	6/25	*	1.2	1.3

*program not covered in Gallup surveys

Table 15. SUMMARY OF NIELSEN DATA ON FEELING GOOD AUDIENCE

	Season A (11 programs)	Season B (13 programs)	Season B re-run (13 programs)
Average Audience rating (% of U.S. TV households viewing during average program minute)	1.4	1.2	1.4
Average Audience: AA rating X estimated 1.2 adult viewers per household	1,152,000	986,000	1,163,000
Total Audience rating (% of U.S. TV households viewing six minutes or more per program)	2.8	1.5	1.7
Total Audience: TA rating X estimated 1.2 adult viewers per household	2,539,000	1,620,000	1,174,000
Average share of audience	2.3%	2.4%	3.2%
Range of Average Audience ratings	.8 - 2.6	.9 - 1.9	1.0 - 1.8
Range of Total Audience ratings	1.7 - 4.4	1.1 - 2.0	1.1 - 2.2
Cumulative number of TV households reached by first four programs	6,510,000	2,945,000	*
Cumulative adult exposures for first four programs	7,812,000	3,534,000	*
Average number of programs viewed in first four weeks in households viewing one or more programs	1.2	1.3	*
Cumulative number of adult program exposures:			
Average Audience	12,744,000	13,056,000	15,120,000
Total Audience	25,392,000	16,200,000	18,324,000

* Not ascertained

For FEELING GOOD, Nielsen data indicate that for Season A and the Season B rerun, the audience obtained for repeat showings (largely on weekends in the late afternoon) equalled that obtained for the Wednesday evening original showing. For the first run of Season B programs, however, the Wednesday audience was twice as large as that for non-Wednesday shows (Table 16). This difference may be attributable to the fact that the first run of Season B programs occurred in the April-June period, opposite reruns on the commercial networks.

Data obtained from the NORC sample of induced viewers during the first half of Season B was generally parallel to the Nielsen data--that is, about twice as many viewers saw the initial programs (in Dallas, at 9:30 p.m. on Sundays) as the repeat telecasts (Table 17).

Viewing of Multiple Programs. An assumption common to most advertising campaigns is that several exposures of a message are normally required before the message can be expected to "register" and thus have a chance of producing the desired effect. The scheduling of topics in the original outline for Season A called for each topic to be treated on several different programs separated by an interval of three weeks or longer, in the expectation that exposure to the content of one program might be reinforced by exposure to similar content on a later program. Of course, this presupposes a reasonably high level of repeat viewing.

Nielsen estimates of cumulative audiences for the first four programs in Season A and the first four programs in Season B indicated that the average numbers of programs viewed during those one-month periods (in households viewing at least one episode) were 1.2 and 1.3, respectively. These figures are somewhat below the average for commercial network entertainment series, which average about 2.0, but are similar to those for other PBS evening series.

Table 16. AUDIENCE RATINGS FOR WEDNESDAY NIGHT VS. OTHER TIMES (NIELSEN)

	Season A (average for 11 programs)	Season B (average for 13 programs)	Season B rerun (average for 13 programs)
Average Audience--Wednesday evening	.7	.8	.7
Average Audience--other times	.7	.4	.7
Total Audience--Wednesday evening	1.4	1.0	.8
Total Audience--other times	1.4	.5	.9

Table 17. TIMES OF VIEWING SEASON B PROGRAMS IN DALLAS (NORC)

NORC Wave 3.5, Q 26; and Wave 4, Q 29: When did you watch FEELING GOOD during the week of__________?

Program viewed: Base N:	B-2 (N=237)	B-3 (N=237)	B-4 (N=237)	B-5 (N=211)	B-6 (N=210)	B-7 (N=211)
Viewing times:						
Sunday 9:30 p.m.	46%	43%	43%	56%	50%	31%
Tuesday 2:30 p.m.	8	14	10	12	13	12
Thursday 12:15 p.m.	11	11	11	7	10	10
Don't know	2	3	2	8	7	11
Didn't see	33	29	34	17	20	36

In February 1974, for example, the comparable figures for "Theatre in America" were 1.1; for "Humanities Film Forum", 1.2; for "Special of the Week", 1.3; and for "Masterpiece Theatre", 1.8.

Projecting from the limited Nielsen data and from viewing recall data in the Response Analysis study, it seems likely that less than 5% of the adults who watched FEELING GOOD at some time viewed more than four programs in the series. This would place a considerable limitation on the reinforcing effects originally intended--and would lead to lowered expectations regarding the potential impact of the series.

Partial Viewing. In addition to the requirements noted earlier for a program or series to have a potential effect--such as ability to receive a PBS signal, awareness of the program, and availability to view when the program is being telecast--attention to the program is a critical factor. Someone who watches only a part of a program, or who engages in other activities while viewing, presumably is less likely to be influenced by the program than someone who attends closely to all of it.

Data on Subsample A in the NORC study provide some indication of the extent to which only parts of programs were viewed (Table 18). These data pertain only to viewing of Season A programs, and are consistent with Nielsen data which indicate that the Total Audience (households viewing six minutes or more) for these programs was twice as large as the Average Audience (households viewing during the average program minute)--2.8 vs. 1.4. This difference was much smaller for Season B, as would be expected with the shorter programs--1.5 vs. 1.2 for the April-June original showings, and 1.7 vs. 1.4 for the July-September rerun.

Given the non-comparability of impact measures for Seasons A and B, and the minimal differences in size of audience attracted, there remain two bases

Table 18. COMPLETE vs. PARTIAL PROGRAM VIEWING (NORC)

NORC Wave 2, Q 16 and Wave 3, Q 12:	Sometimes when people watch a television program, they stop watching for a while because of a telephone call, an unexpected visit from a neighbor, or something like that. How about you--thinking of the FEELING GOOD programs you have watched recently, did you...

	Wave 2 (N=80)	Wave 3 (N=154)
Usually watch each program completely	47%	43%
Usually watch most of it	36	34
About half of it	13	18
Less than that	4	5

for comparison (other than critical reviews, which tended to be more favorable for Season B): (1) the demographic composition of the audiences attracted by Seasons A and B, and (2) audience evaluations of the two program formats.

Audience Characteristics. Data from RAC permit analyses of audience demographic composition. First, there is the demographic profile of the entire pretested posttest sample, within which the profiles of the following subgroups are relevant: (1) nonviewers; (2) viewers of some programming in both Seasons A and B; (3) viewers of Season A only; and (4) viewers of Season B only. If, relative to the other, either Season A or B had elements that were particularly appealing or particularly unattractive to some demographic subgroup, one would expect this to be reflected in a step-wise data progression, highest to lowest, as follows:

Demographic subgroup proportions	If Season A is more appealing	If Season B is more appealing
Highest:	viewers of Season A only	viewers of Season B only
Middle:	viewers of Seasons A plus B	viewers of Seasons A plus B
Lowest:	viewers of Season B only	viewers of Season A only

As indicated in Table 19, this three-step progression did occur with three demographic variables of interest: education, sex, and age. Among RAC respondents, Season A (relative to Season B) attracted somewhat more highly educated viewers, somewhat greater proportions of men, and a younger audience.

Data which permit comparisons of the audiences for Seasons A and B on selected demographic characteristics were also obtained by Gallup and by Nielsen. Gallup found no significant differences in viewer characteristics across four surveys (two in Season A and two in Season B). Nielsen's cumulative viewing figures for the first four programs in Season A and the first four in Season B indicated that the latter programs were attracting smaller proportions of low-income and low-education viewers. The explanation for these divergent findings is not clear, but may lie in the use of quite different data collection methods and population samples by RAC, Gallup, and Nielsen.

Table 19. AUDIENCE COMPOSITION DIFFERENCES IN SEASONS A AND B (RAC)

Education:	college	high school	less than high school	Base N
	%	%	%	
total pretested sample:	50	37	13	(3705)
nonviewers:	48	37	15	(1947)
view Season A only:	57	32	11	(260)
view Seasons A & B:	50	37	12	(913)
view Season B only:	47	36	17	(585)

Sex:	male	female	Base N
	%	%	
total pretested sample	25	75	(3705)
nonviewers:	26	74	(1947)
view Season A only:	32	68	(260)
view Seasons A & B:	24	76	(913)
view Season B only:	23	77	(585)

Age:	18-34	35-54	55+	Base N
	%	%	%	
total pretested sample:	41	36	23	(3705)
nonviewers:	41	35	24	(1947)
view Season A only:	54	34	12	(260)
view Seasons A & B:	45	33	22	(913)
view Season B only:	35	36	28	(585)

Evaluative Reactions of Viewers. In comparing Seasons A and B, it is also important to examine evaluative reactions of the audience members themselves. Relevant data from formal interview/questionnaire items are available from both the NORC and RAC studies. Additional insights are provided by responses to open-end items askod at the end of the NORC and RAC posttest interviews/questionnaires.

In the NORC study, 204 respondents in Treatment Group A (those induced to view and be interviewed) were asked four questions regarding preferences for Season A or B. Unfortunately, these data are not subdivided by level of actual viewing in the series, but it can be assumed that over 90% of the group saw some of the programs: 95% of this group claimed to have seen some of the Season A programs, and 89% claimed to have seen some of the Season B programs. The opinions, therefore, are mostly based on viewing experience, but the high viewer/low viewer opinions cannot be isolated. The four relevant NORC items are displayed in Table 20. The pattern of responses is consistent and clear-cut: by a ratio of almost three to one, the NORC respondents preferred Season B over Season A.

The RAC study featured a branching question near the end of the posttest questionnaire, which (1) directed FEELING GOOD viewers to respond ("mostly agree", "mostly disagree", "not sure") to each of nine evaluative propositions about the series; while (2) directing FEELING GOOD nonviewers to respond to a checklist of eight possible reasons for not viewing the series.

In the nine questions for FEELING GOOD viewers, two items are very similar to two of the NORC comparative items reported earlier:

> Q26-a-h: I preferred FEELING GOOD with "Mac's Place" more than with Dick Cavett;
>
> Q26-a-i: FEELING GOOD was better with one topic per show than it was with several topics.

Two other RAC items for FEELING GOOD viewers were relevant to comparative evaluations of Seasons A and B, but did not require the respondent to choose one over the other:

> Q26-a-b: Dick Cavett was a good host;
>
> Q26-a-c: "Mac's Place" was entertaining.

The remaining five items in RAC Q26-a relate to the series as a whole, and cannot be associated particularly with either Season A or Season B.

Table 20. EVALUATIVE COMPARISONS OF SEASONS A AND B BY NORC INDUCED VIEWERS (FOUR INTERVIEW ITEMS)

Item: As you know, FEELING GOOD was taken off the air for about 2 months during the winter. When it came back on in April, the new programs were different in several ways from the old ones. We'd like to ask you a few questions about some of the changes that were made.

Q40: First, let's talk about the length of the show. Do you prefer a half-hour show or an hour show? (N = 204)

prefer half hour: 72%
prefer hour show: 25%
no preference: 3%

Q41: On the old FEELING GOOD show, each program was about several different topics such as cancer, exercising, and heart attacks. On the new FEELING GOOD, each program is about only one topic, such as breast cancer. Which do you prefer--several topics on each program, or only one topic on each program?

prefer several topics: 26%
prefer only one topic: 69%
no preference: 5%

Q42: The old FEELING GOOD show usually took place in a restaurant called Mac's Place. On the new FEELING GOOD, Dick Cavett is the host, and he introduces the guests or the topic to be discussed. Which do you like better - - Mac's Place or Dick Cavett?

like Mac's Place better: 25%
like Dick Cavett better: 69%
no preference: 5%

Q43: On the whole, which version of FEELING GOOD did you prefer- - the old one or the new one?

preferred the old one: 23%
preferred the new one: 71%
no preference: 7%

The RAC evaluative data from FEELING GOOD viewers are available for three categories of viewers: (1) those who reported some viewing in both Seasons A and B; (2) those who reported only Season A viewing; and (3) those who reported only Season B viewing. The two latter categories of viewers (viewers of Season A only and Season B only) had a critically high non-response rate, much higher than that found in other questionnaire items, and no explanation for this is apparent. Across the nine evaluative items, viewers of Season A only varied from 37% to 46% non-responses, averaging 41% non-response. Across the same nine items, viewers of Season B only varied from 74% to 80% non-response, averaging 77%. A casual reference to other questionnaire items in the same posttest suggests a typical non-response rate on any particular item to be less than 5%. One has the choice of attempting to interpret responses on these particular items, in the case of the Season B-only viewers, from less than a fourth of the eligible respondents, or of not attempting to interpret the pattern. The decision made here is to attempt no interpretation of responses for either the viewers of Season A only or Season B only. (The RAC report did interpret, with several caveats, the data from the two samples with extremely high non-response rates. The RAC conclusions differ from those reported here because different data bases were used.)

Even among the viewers of both Seasons A and B, there is a significant non-response problem, ranging from 23% to 25% across the nine items, and averaging 24% non-response. Being the best of the three samples, however, these data will be examined, with the caveat that the evaluative reactions of 24% of these 913 respondents are unknown. The data are presented in Table 21.

Although the RAC data are somewhat less clear-cut than the NORC data, as influenced to an unknown extent by a 24% non-response rate on these items, the conclusion implied is the same: respondents preferred Season B over

Table 21. EVALUATIVE COMPARISONS OF SEASONS A AND B BY RAC RESPONDENTS WHO VIEWED SOME PROGRAMS IN BOTH SEASONS

	(N=913)			
	mostly agree %	mostly disagree %	not sure %	no answer %
I preferred FEELING GOOD with Mac's Place more than with Dick Cavett:	14	30	31	24
FEELING GOOD was better with one topic per show than it was with several topics:	46	11	20	23
Mac's Place was entertaining:	48	8	18	25
Dick Cavett was a good host:	62	4	11	23

Season A. The ratio was two to one in favor of Season B on the dimension of comparing Dick Cavett with Mac's Place. The ratio was four to one in favor of Season B on the dimension of single health topics vs. multiple topics per show. Even when the two seasons could be evaluated in a non-comparative way, the positive evaluation linked with Season B was 62% as opposed to a 48% positive association with Season A.

A final source of data for comparison of Season A and Season B lies in the free responses to open-end questions asked near the end of the NORC interview and at the end of the RAC questionnaire. Of the two sets of free responses, the NORC study provides more direct insight into the comparison of Seasons A and B by way of these two questions:

NORC Wave 4, Q45:	Think of all the FEELING GOOD shows you've seen. What have you liked most about FEELING GOOD?
NORC Wave 4, Q46:	What have you disliked most about FEELING GOOD?

Some but not all of the responses to these two questions can be linked to Seasons A and/or B. In spite of the methodological limitations of free response data (e.g., no assured reference to a common topic, dependency on verbal skills, inclusion of extraneous information, and relatively high non-response rates), these free responses do tend to humanize an otherwise statistical portrayal of the respondent and her relationship to the series. To indicate the flavor of the NORC free responses that could be associated with one season or the other, examples of positive and negative reactions to both Seasons A and B are given in Table 22.

Although the comments above were balanced in number (pro and con), a tabulation of the total comments to these two NORC items (liked best, liked least) indicate that the majority of the season-related positive references were associated with Season B, and the majority of the season-related negative

Table 22. SAMPLES OF FAVORABLE AND UNFAVORABLE FREE-RESPONSE COMMENTS ON SEASONS A AND B (NORC)

	Favorable	Unfavorable
SEASON A	R #1061: The variety of the first series. I really enjoyed the entertainment of the first series.	R #1020: Mac's Place was hard to follow -- too much comedy.
	R #1184: I liked the old shows where the people acted out what they were talking about. If you had a younger person, they would watch the old show better than the new one.	R #1039: I like all of them. Not the ones at first: I couldn't get any understanding out of them. I mean they tried to express too much in an hour. It's better to understand one thing than not understand any.
	R #1218: I liked when they would all gather at Mac's Place. I just liked to hear them talk.	R #1045: The little sillies that were coming your way on the old show -- too much like SESAME STREET, on a serious topic.
SEASON B	R #1086: On the Dick Cavett show, it's presented at a level where everybody can grasp it. It's presented in a good manner. The other one was on the silly side. This one is compact...	R #1142: (I didn't like) the new program; I didn't like the interviewing. Talk shows is (sic) not my thing.
	R #1227: The new shows were more like real people. Dick Cavett's one of my favorite people, and he presented it better than Mac's Place. He got more involved in it.	R #1152: Well, after the new ones came on, it was harder to keep my interest up, unless it was something I was especially interested in, than with the old Mac's Place shows. I liked the variety and comedy of the older shows better. The new one is kinda boring.
	R #1194: Well, the new program was well-written and put together, and not silly; and I liked the way the information was presented. You can sit down and read a book, but watching TV is easier.	R #1245: (I dislike) the new shows. In the old ones they showed you things and discussed it later at Mac's Place, and I could catch it twice. Dick Cavett's place was too adult. It was very easy on the second show to let your mind wander.

Table 23. SAMPLES OF FAVORABLE AND UNFAVORABLE FREE-RESPONSE COMMENTS ON SEASONS A AND B (RAC)

	Favorable	Unfavorable
SEASON A	R #5491: ...Health education need not be dreary lecture sessions. (The) Mac's Place atmosphere reminded you of questions you ran into, plus answered them. R #3178: ...I wish you would return to Mac's Place. Apparently, I missed some valuable topics, but with the second format, it was dull and I didn't watch. R #3103: ...FEELING GOOD is a good program. Mac's Place is the best.	R #4019: ...Viewed Mac's Place, and once was enough. R #5094: ...(I called the local PBS station) to suggest continuance of the Cavett programs because of their greater sophistication. The FEELING GOOD programs prior to Cavett seemed to "talk down"; the characters were such stereotypes that the program, to me, was more unrealistic soap opera not up to educational standards; humor was forced.
SEASON B	R #2806: ...I much prefer factual information without "embroidery". I have a feeling of trust in Dick Cavett, and feel that what is presented is authentic medical information. R #2952: (I) think that (the) Dick Cavett shows were especially good. Had a feeling of believability and sincerity. R #2856: ...I think Dick Cavett is an excellent host for FEELING GOOD.	R #7080: ...Overall, I like the program's manner of presenting material, but prefer Mac's Place to (the) one-item format. R #5539: ...Please -- more of Mac's Place and less of Cavett!

references were associated with Season A.* The conclusion, therefore, remains unchanged: Season B was preferred over Season A.

In the RAC posttest, there were fewer comments specifically directed to Season A or Season B, because the (mail) questionnaire only asked the respondent to describe anything learned from watching FEELING GOOD that he/she didn't know before (Q39), or anything done as a result of watching FEELING GOOD that related to the health of the respondent or his/her family. Consequently, the comments that are relevant here tended to be of the "p.s." variety, or integrated into something learned or done. Samples of the comments relating to Season A or B are presented in Table 23. The RAC free response data have not been formally content analyzed, but a perusal of them indicates that once again the majority of the favorable comments were associated with Season B.

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*We are indebted to Mr. Richard Hezel, doctoral student in Mass Communications at Indiana University, for organizing the NORC free response comments into countable form.

CHAPTER FOUR: EFFECTS OF VIEWING *FEELING GOOD*

Introduction

As described in Chapter Two, the evaluation plan for FEELING GOOD involved a set of complementary studies, each of which provided data essential to the total design. The various elements in the plan were contracted to four independent research organizations whose separate reports are listed inside the cover of this document. A major task of this Summary Report is to synthesize the results of these separate studies in a manner consistent with the original conception. Part of this task was addressed in Chapter Three, where findings from all four studies were brought to bear on a group of media questions and issues. The integration continues here with an examination of series effects and health behavior trends among the respondents studied by NORC, RAC, and Gallup.

The contractors for the two major evaluation studies characterized their findings as follows:

> RAC: "The series, overall, had a measurable impact on viewer behavior and cognition in health areas both less critical and more deeply value-related. Beyond some predilection toward health-oriented media offerings, viewers consistently demonstrated more knowledge about health matters and a greater proclivity to take steps to improve or safeguard their health than nonviewers. Most health areas which showed measurable change were those directly under respondent control and accomplished with a minimum of effort, but there were also examples of viewing impact on behaviors requiring more effort."

> NORC: "We interpret the findings from this field experiment as demonstrating that FEELING GOOD did have a significant impact on several

different measures of health knowledge, attitudes, and behaviors, in a low-income sample of women. Thirty-eight of the outcome measures indicate some evidence of a significant viewing effect (12 with strong evidence, and 26 with partial evidence)."

The first section of Chapter Four presents a brief summary of the relationships among behavioral goals pursued, extent of coverage of the goals in the evaluation, and results. Behavioral goals were selected for this special analysis because change in a variety of health behaviors was a major aspiration for the series. Originally, 11 priority topics and 70 behavioral goals were developed for series planning under Season A assumptions. The changeover to Season B had the effect of reducing the number of behavioral goals: there were reductions in the number and length of programs, as well as in the number of topics addressed within programs. In combination, Season A and the seven Season B programs covered in the evaluation had varying amounts of programming directed to 48 behavioral goals.

Overview of Behavioral Goal Outcomes

The complexity of the evaluation originally planned for FEELING GOOD was increased considerably by the diverse programming strategies employed in the Season A production format and by the subsequent changeover to a different format for Season B. When diverse outcomes and a number of methodological variations are further imposed, there results a very large array of data, each element of which has unique features. This diversity works against analysis and conclusion unless certain decision rules can be used to reduce the complexity to manageable proportions. In theory, a conclusion-oriented analysis of outcomes should take these kinds of factors into account:

1) When has a goal been treated? Should there be an analytic distinction between a single phrase in a script and a total program on a topic?

2) How does one distinguish between a goal that has received only one measure and a goal receiving multiple measures? If multiple measures show mixed results, how is this to be interpreted?

3) What criteria should be used in judging whether a goal has been reached or not reached? Is such a dichotomy the most useful way to evaluate a complex social experiment such as FEELING GOOD? Given statistical significance, how large must differences be to also imply social or substantive significance?

4) Are data collected or analyzed under different conditions of rigor and precision to be weighed equally in drawing conclusions?

5) Should goals extremely difficult and unlikely to be achieved be distinguished from more easily attained goals?

6) Should one differentiate among measures that are in different degrees representative of actual program content?

7) Is it appropriate to make post hoc distinctions in findings based on perceived differences in the quality of measurement items?

8) Can a fair assessment be made of a series devoted to goals that were both high and low in measurability on the basis of only those measures that could be successfully administered?

9) How should one interpret repeated measurements in those cases where an action taken and assessed at one time would make it unlikely or illogical for the respondent to take the action again at a later time, thus resulting in a measurable impact for the first but not the second measure?

Such questions as these pose real problems for the evaluator seeking to produce conclusions about program impact. If every event is considered unique, there are as many conclusions as there are events. At the other extreme, a single overall conclusion runs the risk of requiring vast oversimplification. Given the same set of phenomena, different decision rules will generate different conclusions. Thus the reasonableness, sensitivity and responsibility of the decision rules themselves, which are inherently arbitrary to some extent, should also be evaluated.

Decision rules on several of the above questions are employed here to give one view of outcomes concerning behavioral goals addressed in the series. The item-specific detail in the remainder of this chapter will have more precision, while such detail is sacrificed here to provide the overview.

Procedures. For this analysis, the behavioral goals originally developed for series planning were compared with those actually covered in Seasons A and B. There were 45 goals (including 9 not listed originally) which received some amount of programmatic coverage in topic-specific areas, plus three topic-nonspecific behavioral goals on asymptomatic physical examinations and health information-seeking. These 48 goals, and the various measures used to assess them, are the ingredients for this quantitative summary of outcomes.

First, the 48 behavioral goals were reduced to 33 goals, since 15 were not specifically assessed. In most cases this was a function of the measurability of the item with the methodology at hand, and the goal area was therefore covered only with information items. The distribution of the number of measurements per goal across all 48 goals was as follows:

Measurements per goal	Number of goals
0	15
1	11
2	7
3	9
4	2
5	1
6	1
7	2

In reviewing the measured results, two decision rules were applied:

Rule #1: When a behavioral goal received multiple measures, the outcome status of that goal was determined by the measure or measures obtaining the highest level of significance, or reflecting the greatest degree of viewing impact.

Rule #2: Every measured goal was placed in one of three outcome categories: strong evidence of effect, partial evidence, or no evidence. The use of more detailed categories covering variations in the number of statistical contrasts made per measure and the number of measures per goal would have spread the distribution out to an uninterpretable extent.

The outcome categories are defined as follows:

Strong evidence: means that one or more measures of that goal yielded unambiguous and statistically significant differences with appropriate comparison groups.

Partial evidence: means that there was evidence of a viewing effect but it was equivocal for one of several possible reasons:

a. an insufficient number of contrasts within a measure were statistically significant;

b. the data were highly suggestive but fell short of statistical significance;

c. frequent viewers were significantly different from nonviewers but not from less frequent viewers;

d. there were indications that the finding was substantially confounded with some nonviewing effect.

No evidence: means that there was no evidence of a viewing effect.

Results. The 33 measured behavioral goals* were distributed into the three outcome categories as follows:

Strong evidence - 10
Partial evidence - 14
No evidence - 9

By using a level of abstraction which transcended the unique features of each attempt at behavioral change, it was determined, under the decision rules specified above, that there was some evidence of viewing impact for 24 of the 33 behavioral goals measured, and that there was better-quality evidence for 10 of these 24 than for the other 14. In the absence of measures for other goals treated in the series, the extent to which they may have produced desired effects could not be estimated.

Strong evidence of effects was found regarding these goals:

- heart disease (seeking information about obtaining heart checkups*)
- nutrition (having more fresh fruit or fruit juice)
- breast cancer (encouraging someone to have a doctor examine her breasts;* women performing breast self-examinations)
- accident prevention/control (learning and posting the number of the local poison control center and other emergency numbers)
- vision (having an eyesight examination)
- hypertension (seeking information about obtaining a blood pressure check;* encouraging someone to have a blood pressure check)

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* Most of these goals were specified in advance as program objectives; the remainder were treated in the series as it developed and thus were also included in the evaluation. The latter items are marked with an (*).

- uterine cancer (encouraging someone to have a Pap test)
- information-seeking (sending for health information offered on TV*)

Partial evidence of effects was found regarding these goals:

- alcoholism (examining drinking habits to detect a potential problem; seeking information about help for a drinking problem)
- mental health (encouraging someone to seek professional help for an emotional problem*)
- nutrition (using a steamer to cook vegetables*)
- accident prevention (storing hazardous substances out of children's reach)
- doctor/patient communications (writing down symptoms before visiting a doctor; asking a doctor to explain diagnosis, treatment, etc.)
- prenatal care (encouraging someone to see a doctor early in pregnancy*)
- vision (taking a preschool child for a vision screening)
- dental care (cutting down on sweet snacks for children)
- hypertension (getting a blood pressure check)
- hearing (seeking information on where to get children's hearing checked*)
- immunizations (taking a preschool child for immunizations)
- physical examinations (obtaining a physical examination*)

No evidence of effects was found regarding these goals:

- nutrition (reducing consumption of foods high in saturated fat)
- breast cancer (women asking a doctor or nurse to teach them how to do a breast self-examination)
- exercise (engaging in moderate physical activity daily)
- dental care (making a trial use of disclosing tablets) [Note: 6,000 viewers sent requests for a sample of disclosing tablets offered on one program, which indicates a direct effect. However,

the RAC and NORC studies did not find differences between viewers and nonviewers in use of such tablets.]

- hearing (taking a preschool child for hearing screening)
- health insurance (seeking information about costs and benefits of health insurance plans)
- uterine cancer (women having a Pap test; seeking information about how to obtain a Pap test*)
- physical examinations (encouraging someone to have a physical examination*)

The following goals were not measured directly:

- heart disease (people in high-risk categories for heart disease having a medical checkup; people encouraging others in high-risk categories for heart disease to have a medical checkup)
- alcoholism (discouraging others from driving after excessive drinking)
- parenting (parents engaging in activities to stimulate language development in children; parents preparing children for significant changes in their life situation)
- mental health (seeking professional help for an emotional problem)
- nutrition (eating more foods rich in vitamin A; giving children more nutritious snacks)
- breast cancer (encouraging someone to do breast self-examinations)
- accident prevention (avoiding circumstances which commonly lead to burn injuries)
- prenatal care (women seeking prenatal care early in pregnancy)
- exercise (checking with a doctor before starting a strenuous exercise program)
- stress (engaging in appropriate actions to reduce stress)
- hypertension (people with hypertension following medical advice for controlling it)
- colon/rectum cancer (people over 40 having a proctoscopic examination)

An attempt was made to characterize the three sets of measured goals in terms of the dimensions used to classify the original goals used in series planning: purpose of action, frequency of action, nature of interaction with health care providers, beneficiary of action, and target audiences (see p. 9). No clear patterns emerged. It appears likely that the differences in measured outcomes were influenced more by variations in the amount and kind of program treatment for various goals than by the characteristics of the goals themselves.

Substantive vs. Statistical Significance. As noted earlier, the criteria commonly used in determining whether between-group differences in an experiment or survey are "significant" may not be appropriate for judging results in an evaluation study. The findings listed above were derived on the basis of standard statistical methods, and there is less than a 5% probability that differences reported as significant were due to chance. However, the absolute size of the differences--rather than the fact that they were large enough to be non-chance--bears more directly on the substantive importance issue.

The differences between comparison groups in reporting various health behaviors ranged from fairly small (e.g., 3% for seeking information about obtaining heart checkups, blood pressure checks, and help for a drinking problem) to substantial (e.g., 23% and 26% for women doing breast self-examinations). Across 39 measures which provided either significant or suggestive evidence of series effects on behavior, appropriate comparisons showed 11 percentage differences of 5% or less, 18 differences of 6-15%, and 10 differences of 16% or more.

Such differences may not be generalizable to all viewers of the series, since the samples in the RAC and NORC studies were not intended to be representative of the national population. Projections from a limited base always involve some risk of error, and in the present case the risk may be greater than usual. Thus any estimates of the numbers of people taking actions as a result of the series (based on observed percentage differences) would have to be regarded as highly tentative, but they may still be useful. For example, if the gain in breast self-examinations (Tables 38-39) were to be projected to the national viewership of FEELING GOOD, it would suggest that more than 100,000 women were influenced to do a BSE. Similar projections in other areas would indicate that some 50,000 viewers encouraged someone to have a Pap test (Tables 85-86), and that perhaps 200,000 changed their eating habits to some extent (Table 32). Such projections could be made for each of the goals for which significant effects are reported.

Although these projections are imprecise and some allowance must be made for inflation in self-reported actions, figures of this kind do provide one easily-understood estimate of series impact. The health consequences of the actions (as eventually reflected in morbidity and mortality statistics) could be substantial but their assessment would require measures over a period of years.

Introduction to Topic-Specific Findings

The major section of Chapter Four presents data and conclusions from three studies dealing with health knowledge, attitudes, and behaviors. This includes trend data, descriptive data, suggestive and statistically significant data on viewing effects, and narrative or tabular presentation of items on which no impact was observed. For convenience, the large amount of data is subdivided into topic sections such as breast cancer, accident prevention, and vision, which are presented in order of the amount of program time devoted to them. Clearly, several topics such as nutrition, exercise, and heart disease are interrelated, and the assignment of some items to one or another topic category was somewhat arbitrary. The presentation within topic categories also includes a description of behavioral goals and the information points intended to support these goals, as well as brief descriptions of related program segments.

The topic sections conclude with some examples of responses to the following open-end questions asked at the end of the RAC and NORC posttests:

RAC Q 39: Was there anything you learned from watching FEELING GOOD that you didn't know before?

RAC Q 40: Is there anything related to your own or your family's health that you or someone in your family did as a result of watching FEELING GOOD?

NORC Q 44: Now think of all the FEELING GOOD shows you've seen since the program began. What do you think you've learned from these shows?

NORC Q 47: Have you done anything new or anything differently as a result of watching FEELING GOOD?

Although the responses were not analyzed by the contractors as a part of the evaluation, it may be of interest to note that a substantial proportion of viewers offered examples of things they had learned or done as a result of the series. In the NORC group which received these questions (N = 245), for example, 92% mentioned one or more things they had learned, and 76% described one or more actions taken.

In establishing expectations for possible program effects and in interpreting results, it is useful to know the amount and kind of programming devoted to various topics. The chart on the following page indicates the approximate amount of program time given to each topic area, the number of programs on which each was treated, and the number of segments using different production formats. The listing includes only those programs covered in the evaluation--i.e., all eleven in Season A, and seven in Season B (B-2 through B-8).

TOPICS	PRODUCTION FORMATS USED													
	documentary	song	drama	interview	"vox pop"	"commercial"	comedy monologue or sketch	lecture or demonstration	self-test (quiz)	parody	host comments	other	approx. minutes of treatment	no. of programs
heart disease	1	3	1			3	1	4	2	1	1	2	74	7
alcoholism	1	2	3	1		1	2	1	3		1		73	6
parenting	3	4	2	1	2	2	3						49	5
mental health	2	4	1	1			1				1	1	46	4
nutrition		4				3	2	2		3			41	4
breast cancer	2	1		1			1	2				1	38	2
accident prevention or control		2	1		3	5	2	1				2	37	6
doctor/patient communication and patients' rights	2	1	2	2	4		4	2			1		35	4
prenatal care	1	2				1	3	1				2	34	3
exercise		3	1		1	1				1		1	34	4
vision	2	2				1		1			1		33	3
dental care		2			1	7	2	1		1		1	33	6
stress	1			1		1	1	1			1	1	28	1
hypertension		3				4	3	1				1	26	5
hearing	2	2				1	1	1			1	2	20	2
allied health personnel	1	1	1				1					1	19	2
health insurance		1	1				1					1	11	2
uterine cancer	1	1				1							7	1
immunizations					1	1	1						5	1
colon-rectum cancer								1					4	1

It should be noted that the topic-specific reporting of results artificially isolates the program elements from one another and thus violates to some extent the orientation of the series. The general theme was that lifestyle affects health, and that individuals have more power to influence their health than they may realize. Thus a major purpose was to increase the salience of health as a personal concern, and to enhance viewers' feelings of responsibility and capability in caring for themselves and their families.

The information points conveyed in the programs and assessed as part of the evaluation were not stressed as ends in themselves, but as instrumentalities to behavior change; the points were chosen on the assumption that viewers who learned them (or were reminded of them) would be more likely to take the actions recommended. Programming emphasis was therefore not structured as an instructional series might be to maximize learning. Other kinds of "influence strategies"--such as emphasizing parental role responsibilities or appealing to altruism--were used in the same way as the information content but were more difficult to assess. In some cases, measures of possible knowledge gain were used in the evaluation because adequate measures of specific attitudes or behaviors were not available.

The use of knowledge measures was appropriate for assessing the extent to which information presented in the programs was learned, and it also provided a means of ascertaining "partial" success in some instances where behavioral impact was not demonstrated. However, the fact that such measures were employed should not be construed as implying that the information points were program goals. The primary intent of the series was to motivate adaptive health behavior, and the information provided to viewers was regarded as only one means to that end.

Topic-Specific Findings

Heart Disease

Rationale for choice of topic

Heart disease, the major cause of death and chronic disability in the U.S., kills one million Americans every year. Medical authorities believe that the incidence of heart disease could be cut markedly if people were to take certain preventive measures.

Behavioral goals

1) To motivate persons who are in high-risk categories for heart disease to have a medical checkup.
2) To motivate viewers to encourage family members or friends who are in high-risk categories for heart disease to have a medical checkup.

Additional behavioral goals related to heart disease appear in sections dealing with nutrition (reduction of saturated fat in the diet), hypertension (having blood pressure checked, encouraging others to do so, following medical advice for controlling hypertension), and exercise (checking with doctor before beginning strenuous exercise program, engaging in moderate physical activity daily).

Information to convey

1) Controllable risk factors in heart disease include high cholesterol levels, high blood pressure, cigarette smoking, overweight, lack of exercise, and stress.
2) Other factors are a family history of heart disease, age, sex, and presence of diabetes.
3) A medical checkup can reveal the presence of risk factors

of which a person may be unaware, including those which can be controlled to reduce the risk of a heart attack.

4) Sources of information about preventing heart disease.

Programming on heart disease

Season Program	Segment Title	Running Time	Format
A-2, A-5, A-6	"Thump Thump"	1:12	"commercial"
	Animated film of a man whose heart is visible and also speaks. The heart complains about being in poor shape because the man doesn't exercise enough and eats the wrong foods. When the man decides to take a walk, the heart says, "I love you."		
A-2	"The Heart and How to Keep it Healthy"	2:41	lecture
	Dr. Timothy Johnson provides some basic information about the heart and blood vessels, and describes some symptoms which indicate that a heart checkup should be obtained.		
A-2	"Mate's Heart"	5:36	quiz
	Animation is used to illustrate six questions about risk factors related to heart attacks: weight, stress, physical activity, smoking, blood pressure, and cholesterol level. Narration invites viewers to take the quiz for a spouse or friend, and indicates that a "score" above 13 points identifies a high-risk person.		
A-7	"Tell-tale Heart"	4:43	comedy monologue
	Bill Cosby recalls how, as a child, he frightened his younger brother by claiming that their downstairs neighbor had stuck a dead body through the ceiling. The final part of the monologue offers serious information about heart disease.		
A-7	"Smoking and the Heart"	3:05	lecture/demonstration
	Dr. William Lathan demonstrates the ineffectiveness of filters in removing tar from cigarettes, and describes the effects of smoking on the heart.		
A-7	"I Love My Heart"	3:12	song
	Ken Berry does a campy version of a song-and-dance routine. The lyrics explain why he can't give his heart to anyone as a token of love.		

A-8 "Heart Attack Drama" 12:51 drama

When a middle-aged man has a heart attack at home, his wife and children respond quickly and efficiently in caring for him and notifying the hospital. The dramatization and accompanying narration describe the actions taken by a mobile coronary care unit.

A-9 "A Heart Song" 2:40 song

Martin Mull sings about taking care of his heart by cutting out saturated fats and the girl who causes him so much grief.

A-9 "Chicken and Heart Disease" 2:40 demonstration

Vivian Vance shows how to skin a chicken and explains why eating chicken skin is unhealthy.

A-9 "Chicken Soup" 4:08 parody

In this take-off on an old Marx Brothers movie, the Groucho character is a judge trying a case involving a Mae West-type accused of murdering her husband by serving him foods high in cholesterol.

A-9 "Saturated Fat Quiz" 4:29 quiz

This self-test includes 12 yes-or-no questions pertaining to saturated fat content in food, illustrated by animated graphics. Narration informs viewers that if they answered "yes" to all the questions, they are doing all they should to avoid excess cholesterol and saturated fats in their diets.

B-3 "Coming Back"
(program title)

Dick Cavett as host 4:32 host comments and demonstration

Cavett discusses heart attack recovery and prevention, and takes a test to measure his heart's reaction to stress.

"Sharing and Caring" 12:21 dramatization

A group of women whose husbands have had heart attacks discuss their reactions and the problems of returning heart attack victims to normal routines without stigma or fear.

"Cardiac Meal" 1:25 demonstration

At a restaurant table, Dick Cavett shows the foods he has ordered which are recommended for people who have had a heart attack at some time or who are in a high-risk group.

B-3
(cont.) "First Day Back" 3:53 documentary

Bill Hunt, a sheet metal worker who had a heart attack two years earlier, talks about the problems and satisfactions of returning to work.

"Coming Back" 3:53 song/commentary

Pearl Bailey sings about "coming back into the world" and discusses her own recovery from a heart attack.

Findings. Since it was not feasible to identify respondents at high risk for heart disease, the specified behavioral goals in this area were not measured directly; thus the possible impact of the series on these goals is not known. Findings bearing on other behaviors related to heart disease appear in the sections on nutrition, exercise, and hypertension. The first six categories of information items listed below showed no program impact, largely because of ceiling effects (reflected in the overall percentages).

1) Hereditary aspects of heart disease. RAC Interim 1, Q4-a: If other people in your family have heart disease, your chances of having it are above average (overall, 69% agreed; N = 518). NORC Wave 4: Heart disease tends to run in some families (Q4-m, 85% agree, N = 467).

2) Diet. RAC Interim 1, Q4-b: Eating a lot of fried foods over the years can have a bad effect on the heart (79% agreed, N = 518).

3) Symptom recognition. RAC Interim 1, Q4-c: Which of these things can be symptoms of heart problems . . . (N = 518)

. . . shortness of breath (76%)

. . . pains like heartburn (70%)

. . . sudden chest pains (85%)

4) Opportunities for personal impact. RAC Interim 2, Q7-a: Not much can be done outside a hospital for a person who has a heart attack (71% disagree, N = 466); NORC Wave 4,

Q4-a: Besides watching your diet, there is not much you can do to prevent heart attacks (76% disagree, N = 468); this same item also insignificant in RAC Interim 2, Q11, where 85% of 466 disagreed; finally, this same item was significant in NORC Wave 3, displayed later.

5) Cigarette smoking. NORC: Cigarette smoking increases the chance of heart attack (Wave 3, Q4-m, 88% agree, N = 308; Wave 4, Q4-1, 81% agree, N = 464). In a checklist of several possible consequences of cigarette smoking, 81% of the 466 RAC Interim 2 respondents checked "increases the chance of a heart attack" (Q10-a). Both RAC Interim 2 (Q10-b) and NORC Wave 3 (Q4-q) could detect no viewing impact on the information/opinion item that the effects of cigarette smoking on the body can be reversed when a person quits smoking.

6) Post-heart attack prospects. NORC Wave 4, Q4-b: Once a person has a heart attack, he should do as little physical activity as possible (71% disagree, N = 467). NORC Wave 4 Q15: People who have had heart attacks can never again lead normal lives (89% disagree, N = 468).

Three informational items were found to be statistically significant in NORC Wave 3: (1) Not much can be done outside a hospital for a person who has a heart attack; (2) Besides watching your diet, there is not much you can do to prevent heart attacks; and (3) Heart disease runs in families. On all three of these items, proportions holding correct opinions were higher among Season A High Viewers than both the Season A Low Viewers (Treatment Group A) and the Season A Nonviewers (Treatment Group B). Interpretability

Table 24. HEART CARE: SEASON B SUGGESTIVE INFORMATIONAL EFFECTS (NORC)

NORC Wave 4, Q 10: If a person has heart trouble, which one of these kinds of meat do you think is best for him to eat -- beef, veal, lamb, or pork? (veal)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Program B-3:	Viewer (N=48)	Nonviewer (N=189)	Nonviewer (N=103)	Nonviewer (N=83)
% veal:	29	23	19	16

Table 25. HEART CARE: OVERALL SERIES IMPACT ON INFORMATION-SEEKING (RAC)

RAC Baseline Q8-b and Posttest Q5-b: In the last six months, did you try to get information for yourself or anyone else on where to get a heart checkup? (Yes, I tried; No, I did not try; I already knew it)

	Base N = number responding "no" or "already knew it" for the 6-month interval prior to the series	Proportion of respondents claiming to have sought information about heart check-ups during the series
	N	%
Hi Viewers (viewed 4 or more shows in entire series):	(754)	6
Lo Viewers (viewed 1-3 shows in the entire series):	(918)	3**
Nonviewers (viewed no shows in the entire series):	(1,870)	2***

Significance of difference from Hi Viewers: **p <.01, 2-tail; ***p <.001, 2-tail.

of these significant findings is limited by the fact that in each case the items were found not to be statistically significant in one or two other instances.

There is some evidence that program B-3 affected the proportions recognizing that veal is better than other meats for people with heart trouble. Data are displayed in Table 24.

The one behavioral measure taken in this topic area dealt with information-seeking. RAC Baseline Q8-b and RAC Posttest Q5-b asked: In the last six months, did you try to get information for yourself or anyone else on where to get a heart checkup? (Yes, I tried; No, I did not try; I already knew it). Of those who had not done so before the series, small but statistically significant increments in this behavior were associated with overall frequency of series viewing, as displayed in Table 25.

Conclusions. Information-seeking behavior on heart care was affected in small but statistically significant proportions by the series as a whole. However, most cognitive and opinion items either showed no viewing effects (due in part to ceiling effects) or mixed effects (succeeding on some measures but not on others for the same item). There was suggestive evidence that program B-3 increased the recognition that veal is a good meat for persons with heart trouble to eat.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of heart disease:

"I learned how you can have symptoms of a disease and not know it, like high blood pressure and now I can recognize things when they are coming on rather than wait till it's too late. And we're really careful about fatty foods and saturated fats."

"As an air traffic controller my husband runs an extremely high risk of heart attack. I feel I can better cope with the situation should it arise by watching the program."

"I learned that some heart attack patients can recover sufficiently to hold down a job again by therapy and exercise suited to their ability."

"My mother has had three heart attacks and it has made me understand what she went through and how she has learned to adjust to her life."

"I don't let my husband eat as many eggs. I guess I'm more conscious of my heart and health before something goes wrong."

"I learned that sex is still permissible between married couples after the husband has had a heart attack."

"I learned how quickly good help is available for heart attacks. The program made me conscientious about health problems and preventions of which I was already cognitive but neglectful."

"I learned how to help my husband who has had a heart attack to live a better and normal life."

"I have a check up every three months with a heart doctor and my wife cooks proper meals for a heart condition."

"I learned that there are organized programs to aid the long-term recovery of heart attack victims -- and their wives."

"I realized that the wives of heart attack patients have the same apprehensions that I have."

"After the Dr. told me I had a heart condition I was very careful with myself but now I've seen those cardiac patients doing pushups and decided I'd try to do that too, in moderation, so I'm doing more housework than ever and it's within reason, so I'm better off."

Alcohol Abuse and Alcoholism

Rationale for choice of topic 1 (drinking and driving)

About half of all fatal motor vehicle accidents involve a drinking driver, and alcohol-related crashes cause injuries to an estimated 500,000 people each year. Educational campaigns aimed directly at the drinking driver have not been very successful, but there is reason to believe that friends, party hosts, and family members can be influenced to keep an impaired person from driving.

Behavioral goal 1

To motivate viewers to discourage others from driving after excessive drinking.

Information to cover

1) Driving after drinking too much greatly increases the chances of accident involvement.
2) Warning a person who has been drinking that this increases the risk of an accident or arrest is seldom effective.
3) There are positive alternatives for discouraging persons from driving after excessive drinking.

Rationale for choice of topic 2 (responsible drinking)

Of the 100 million drinkers in the U.S., an estimated 10 million are alcoholics. There is much public uncertainty over the difference between "social drinking" and "problem drinking". Most people are unaware of the early symptoms of alcoholism in themselves or others, and thus fail to perceive the gradual development of a drinking problem.

Behavioral goal 2

To motivate viewers to examine their drinking behavior to aid in recognizing whether they have a drinking problem.

Information to convey

1) The behaviors which may indicate the presence of a drinking problem.
2) The behaviors which reflect responsible drinking.
3) That denial of a drinking problem is common among people who drink excessively.
4) That alcoholism can often be treated successfully.
5) That early recognition of the problem greatly increases the chances for successful treatment.
6) Voluntary and public agencies and other sources of information about the diagnosis and treatment of alcoholism.

Rationale for choice of topic 3 (families of problem drinkers)

The estimated forty million family members of alcoholics in the U.S. experience a variety of problems. Many family members cannot contribute to the recovery of the problem drinker because of an inability to cope with their own feelings, and many need help in determining how to interact with the problem drinker in a constructive way.

Behavioral goal 3

To motivate members of families of problem drinkers to seek counseling as appropriate.

Information to convey

1) The organizations from which family members of problem drinkers can obtain help locally, often without charge.

2) The benefits which counseling can provide.

3) That seeking help need not entail stigma or embarrassment.

4) That feelings of guilt, resentment, frustration and fear are common in families of problem drinkers.

Programming on alcohol abuse and alcoholism

Season Program	Segment title	Running Time	Format
A-4	"On the Wagon"	4:57	sketch
	Charlie Callas and others consider borderline alcoholism in a restaurant scene involving dishes prepared with alcohol.		
A-4	"Life Quiz: Alcohol"	2:18	self-test
	Animated graphics with narration present 12 questions designed to identify early symptoms of problem drinking.		
A-4	"Mama's Day"	4:18	song
	Tammy Grimes sings a ballad about a housewife, bored with routine, who drinks her way through the day.		
A-7	"Teen Alcohol Quiz"	2:39	self-test
	Animated graphics with narration present 10 questions for teenagers to identify early symptoms of problem drinking.		
A-7	"I See Your Future"	2:51	song
	Sally Kellerman sings a song dealing with parental influence through example: "I see your future in whatever I do . . ."		
A-7	"If You Really Love Me"	5:11	documentary
	An alcoholic, his family, and psychiatrist discuss the personal and family consequences of alcoholism.		
A-7	"Parents Alcohol Quiz"	1:32	self-test
	A ten-question test designed to help parents of teenagers identify behaviors indicative of a potential drinking problem.		
A-7	"Mac's Place segments	15:05	comedy/drama
	Mac, whose brother has a drinking problem, learns that giving money to an alcoholic relative can do no more harm than good.		

A-10 "Alcohol Sketches" :47 comedy sketches

Three very brief exchanges about drunk driving between couples at a party.

A-10 "Drinking and Driving Film" 3:00 drama

Leaving party, wife asks her intoxicated husband for car keys but finally allows him to drive. She berates herself for not having been firmer, and thinks of arguments she could have used. On way home the car crashes and she is killed.

A-10 "Blinders" :55 demonstration

A simulation of what it is like to drive drunk. Impairment of vision and reflexes is shown by man wearing greased glasses, blinders, and weights on feet.

A-10 "Fred Goes Drinking" 1:15 "commercial"

Middle-aged Fred is shown drinking heavily at a party while narrator notes that "Fred loves drinking at a party . . . that's why he never drives himself home." Final scene shows Fred swinging from hook of tow truck as it moves down street.

B-2 "A Little Pick-Me-Up"

Dick Cavett as host 3:26 host comments

Cavett introduces topic of excessive drinking, provides bridges to drama and group interview, and offers comments at close of program.

Dorothy 12:00 drama

Estelle Parsons portrays an alcoholic housewife who denies her problem. Background music for the drama is "Mama's Day", sung by Tammy Grimes.

South Oaks interview 8:28 group interview

Recovered alcoholics at a treatment center make the points that anyone can be an alcoholic, denial of the illness is common, and recovery is possible.

Findings. The NORC baseline asked (Q20-j) whether the respondent or anyone else in the family ever had trouble caused by too much drinking; 2% said yes (N = 398). The same question was asked again on NORC Wave 4 (Q22-j), this time in reference to the past six months; 5% said yes (N = 468).

Several items reflecting information gain from Season A and B programming on the topic of alcoholism are displayed in Table 26. There was no impact on the proportions disagreeing with the statmment that money should be given to persons with a drinking problem (NORC Wave 3, Q5). There was no evidence of informational impact within the RAC study on the statement that alcoholism is easier to treat in advanced stages (disagree), but there wa[illegible] strong evidence of an effect for this item within the NORC study.

NORC informational data, displayed in Table 26, provide strong evidence of an effect in learning that parents who drink a lot are more likely to have children who drink a lot, when analyzed by categories of viewership for program B-2. A similar effect, suggestive but not statistically significant, from program A-7 was detected by the RAC study; it also suggested learning that children of parents who don't drink at all are also susceptible. Data are presented in Table 27.

Program A-4 dealt in part with a self-quiz on alcoholism; RAC Interim 1 (Q1-j) found a suggestive but not statistically significant indication of behavioral effect, as shown in Table 28.

Only very small minorities of respondents reported attempts during the series as a whole (i.e., in the last six months) to "get information on where to get help for drinking problem" (RAC posttest, Q5-d). Data are displayed in Table 29.

For trend data, the first two Gallup surveys asked whether, in the previous two months, the respondent had taken a self-quiz on drinking habits from newspapers or TV. Proportions responding "yes" were 9% in Survey 1 (December, 1974, N = 1517), and 7% in Survey 2 (February, 1975, N = 1544).

Table 26. ALCOHOLISM: KNOWLEDGE/OPINION EFFECTS (NORC)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Item: NORC Wave 4, Q 4-c: Only people who drink so much that they can't work can really be called "alcoholics". (disagree)				
Program B-2:	Viewer	Nonviewer	Nonviewer	Nonviewer
	(N=78)	(N=158)	(N=103)	(N=84)
% disagree:	82	65**	65**	61
Item: NORC Wave 4, Q 4-d: It is easier to cure a person of alcoholism if the person doesn't realize that he's an alcoholic. (disagree)				
% disagree:	86	75*	77	77
Item: NORC Wave 4, Q 16: Parents who drink a lot are more likely to have children who drink a lot. (agree)				
% agree:	53	41*	39*	31
Item: NORC Wave 3, Q 4-f: Alcoholism is easier to treat in its later stages when its symptoms are more definite. (disagree)				
	(N=66)	(N=97)	(N=46)	(N=84)
% disagree:	86	75*	70*	63

Significance of difference from viewer group: *$p < .05$, 1-tail; **$p < .01$, 1-tail.

Table 27. ALCOHOLISM: SEASON A SUGGESTIVE INFORMATIONAL EFFECTS (RAC)

Interim 2, Q 9:

Which of the following types of teenagers are more likely to drink than other teenagers:	Viewed Program A-7 (N = 56)	Viewed A-5, 6 or 8 (N = 67)	A-4 - A-8 Nonviewer (N = 328)
Children of problem drinkers	58%	52%	45%
Children of people who don't drink at all . .	22%	14%	12%

Table 28. ALCOHOLISM: SEASON A SUGGESTIVE BEHAVIORAL EFFECTS (RAC)

RAC Interim 1, Q 1-j: (In the last two months, have you ..) Taken a self-quiz on drinking habits from newspapers, TV, or a pamphlet? (yes)

	Viewed Program A-4 (N = 36)	Viewed A-1, 2 or 3 (N = 105)	A-1 - A-4 Nonviewer (N = 377)
% yes:	13	6	8

Table 29. ALCOHOLISM: SUGGESTIVE EFFECTS ON INFORMATION-SEEKING (RAC)

	High Viewers: Viewed 4 or more shows in Season A &/or B	Low Viewers: Viewed 1-3 shows in Season A &/or B	Nonviewers: Viewed no shows in Season A or B
Pretested Respondents			
N:	(802)	(956)	(1947)
% seeking information:	5	3	2
Panel Control Unpretested Respondents			
N:	(275)	(297)	(494)
% seeking information:	8	4	1

Conclusions. The NORC study found strong evidence that Season A programming increased the proportions aware that alcoholism is more easily treated in its early stages. NORC also found strong evidence of a program B-2 impact on the proportions (1) disagreeing that people can be called alcoholics only if they drink so much that they can't work; and (2) agreeing that parents who drink a lot are more likely to have children who drink a lot. Weaker evidence was found by NORC of program B-2 impact on the proportions disagreeing that treatment of an alcoholic is easier if the person doesn't realize that he or she is an alcoholic.

Suggestive evidence on this topic in the RAC study, falling short of statistical significance, included the following:

1) Viewers of program A-7 were more likely than viewers of other shows to report that teenagers of parents who drink a lot, or who don't drink at all, are more likely to drink.
2) Viewers of program A-4 were more likely than viewers of other shows to have taken a drinking self-quiz in the preceding two months.
3) Frequent viewers of the series as a whole were more likely than infrequent or nonviewers to have sought information on where to get help for a drinking problem.

Two of the three behavioral goals on alcoholism were measured. As indicated above, there was partial or suggestive evidence for an effect on examining one's drinking habits and on seeking information about sources of help for a drinking problem.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of alcohol abuse and alcoholism:

"I've become extremely conscious of my drinking and have analyzed how I feel after and now drink no mixed drinks -- when with friends I have ice and water and the host is the only one the wiser."

"I learned that alcoholism crosses socioeconomic and cultural lines, and that it is definitely a disease."

"As my mother is an alcoholic, the show gave me information on this problem and helped me better understand her problems."

"I watched the program on alcoholism and felt the described situation was not hopeless or helpless for the families of alcoholics."

"I learned that alcoholics should not be ashamed to ask for help, but most don't know they have a problem."

"Watching the show caused me to get more information on alcoholics for my father who does drink heavily."

"My aunt who is an alcoholic has started to believe she has a problem. I think part of the reason is this project."

"I learned that alcoholism can happen to very young people."

"It caused our son to let Daddy know that he recognized a drinking problem. Perhaps someday Daddy will do something about it before it does much more to him."

"My husband has quit drinking and although it is a result of many things, the show helped."

"I encouraged a friend to seek help for a drinking problem."

"I learned that liquor does not cure problems although some people at the time think so."

"My husband has recognized that he can never take another drink."

"I have a relative whose life resembled the housewife's, and watching the show gave me the courage to talk to her about alcoholism because I learned so much from this episode and recognized her symptoms."

Parenting

Rationale for choice of topic 1 (language development)

During the first two years of life, children acquire information and capabilities which are critical to the effective development of language. Many parents are unaware that even very young children benefit from hearing a language spoken normally by adults. In homes where English is not the first language, parents may be reluctant to talk to a young child because of fear that this could impede the child's learning of English.

Behavioral goal 1

To motivate parents or others responsible for child care to engage in activities which stimulate language development in their children.

Information to convey

1) Babies learn to talk by imitating the people around them. Thus, normal speech is more effective than "baby talk" in stimulating the development of appropriate speech patterns.
2) Naming objects, reading aloud, storytelling, singing, and simply allowing young children to hear adult conversation can be beneficial long before an infant learns to speak.

Rationale for choice of topic 2 (preparation for changes)

Most children experience uncertainty and fear when faced with life changes such as the arrival of a new baby, beginning school, undergoing surgery, a death in the family, and parental separation. If parents can anticipate the child's reactions to a new situation and provide understanding and explanations, the likelihood of adjustment problems can be reduced.

Behavioral goal 2

To motivate parents to prepare their children for any significant change in their life situation.

Information to convey

1) Children normally experience a fear of rejection as the birth of a new baby nears. Parents, particularly mothers, should make special efforts to explain that they will still love their present child(ren) when the baby comes. Giving extra attention, tolerating regressive behaviors which some children engage in temporarily, expressing understanding of feelings of anger or resentment, and pointing out positive aspects of having a younger brother or sister can all help to make a child's adjustment easier.
2) Fear of separation from parents or friends is commonly felt by children in situations involving a move, entering a hospital for surgery, starting school, and a death or serious illness in the family. In any of these "change situations," parents can make things easier for a child by encouraging him to express his feelings, by making him aware that resentment and fear are normal in some circumstances, and by offering reassurance. Honest discussion of the consequences of a life change lets a child know his feelings are understood and can enable him to cope with new situations more effectively.

Programming on parenting

Season Program	Segment title	Running Time	Format
A-4	"Sibling Rivalry"	4:06	comedy monologue
	Bill Cosby discusses how to prepare children for the arrival of a new baby as he describes his own preparation for the birth of a younger brother.		
A-4	"Baby on the Way"	4:38	documentary
	A pregnant woman relates her experiences in preparing her young daughter for the arrival of the baby soon to be born.		
A-4	"Not the Only Baby in Town"	1:59	song
	B.B. King advises parents that "It's not easy to take when you first hear that you're not the only baby around" and offers a song to smooth the way (". . . Don't you feel bad, 'cause nobody means to make you sad . . . all those good times, they don't just end . . . put it this way--you've got a brand new friend. . .").		
A-6, A-8	"Terrible Twos"	:58	"commercial"
	A two-year-old child is shown making a mess of a kitchen by pulling things out of cabinets and drawers. Accompanying narration points out that two-year-olds learn by exploring and making mistakes, and thus that parents need to provide both freedom and guidance.		
A-8	"Baby Talk"	3:56	comedy monologue
	Bill Cosby impersonates an infant who is dissatisfied with adults who use baby talk with him, and points out that this may delay his learning to speak properly.		
A-8	"Goldilocks"	4:38	documentary
	A Spanish-speaking father reads "Goldilocks and the Three Bears" to his young daughter in English and then translates it for her into Spanish.		
A-8	"Sing to the Baby"	2:00	song
	Trini Lopez demonstrates through a song that children learn to speak by imitating the people around them.		
A-10	"Kids Go To the Hospital"	1:45	vox pop
	Two children discuss with an adult their experiences in a hospital.		

A-10 "Mac's Place segments" 3:29 situation comedy/drama

Felipe, Rita's five-year-old son, is told what to expect when he goes into the hospital to have his tonsils removed.

A-10 "I'll Stay with You" 2:12 song

Shari Lewis sings a song to comfort a child who is about to enter a hospital (". . . I'll stay with you all the way through . . . and when you need me I'll be there . . .")

A-10 "Preparing Child for Surgery" 8:34 documentary

A true story showing how parents prepared their preschool daughter for surgery in a hospital.

A-11 "Playing Dead" 4:35 comedy monologue

Bill Cosby recalls how his father prepared him for the death of his dog Patricia, and discusses children's fears about sickness and death.

A-11 "Death of Pets" :32 vox pop

A man asks a young girl about what she thought when her dog died.

A-11 "Clip from 'The Waltons'" 1:20 drama

A short segment from an episode of "The Waltons" TV series in which Jim Bob's pet guinea pig dies.

A-11 "Preparing Children for Changes" 1:51 interview

Dr. Edward Mason discusses with parents the importance of talking openly and honestly with children about their feelings concerning changes in their lives, such as losing a pet, the birth of a new brother or sister, starting school, and changes in family relationships.

A-11 "Changes" 3:00 song

Charlie Rich notes that explaining changes to a child can make life easier, then sings as a father to his son (". . . And there are changes in the world, changes every day . . . someone grows up, someone moves away . . . something gets lost and something gets found . . . so hang onto me while the world turns around . . .").

Findings. Although a considerable amount of programming time was devoted to parenting, much of the material was highly specialized or situation-specific; that is, the goals were relevant only for viewers who had a very young child (language development), had one child and were currently expecting another (preparing child for a new sibling), or had a child facing hospitalization (preparing child for surgery). Thus it was not surprising that the few attitude or opinion items used to assess the effects of program segments on parenting did not indicate significant differences between viewers and nonviewers. Ceiling effects were also present to some extent, as reflected in the responses given below for descriptive purposes and based on all respondents.

1) Language development in young children.
    a. RAC Interim 2, Q8: Babies should be talked to as grownups instead of in baby talk to stimulate language development (85% mostly agreed, N = 466).
    b. NORC Wave 3, Q4-o: Babies should be talked to in baby talk so they can understand it better (79% disagreed, N = 306).
2) Preparation of children for siblings.
    a. NORC Wave 3, Q4-h: It is not important to prepare a child in advance for a new baby brother or sister (92% disagreed, N = 308).
3) Preparation for surgery.
    a. RAC Interim 3, Q6-a: Children who need an operation should be told as little as possible about what is going to happen in the hospital (80% of the pretested respondents disagreed, N = 411; 85% of the unpretested panel control respondents disagreed, N = 353).

Conclusions. Several attempts to develop measures for the behavioral goals on parenting failed to produce items regarded as satisfactory, and the knowledge items eventually used had ceiling effects (as noted above) which precluded any demonstration of possible program impact. Effects might have been found in an assessment covering a longer period of time, which would have increased the number of opportunities for parents to become involved in situations related to the goals, but the period covered was necessarily limited.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of parenting:

"I'm more observant. I'm a little bit more patient, too. I'm more patient with my kids than I used to be. If something happened to the boys, I'm paying much more attention to them and my reactions to what they do. I'm toning down my temper."

"I updated my child's immunizations."

"I like the way Bill Cosby discouraged Baby Talk with children. I have been wanting to put that point over to my relatives, now they understand the reason."

"I've learned to take more interest in my children and their safety."

"I learned that you have to be more concerned about the health of our children. You know our children are healthy and we take it for granted but the show told us to have them checked anyway."

"I learned to take proper care of my children -- how to cook better foods that will help me and them for the rest of our lives."

"I learned how to act when you take kids to the hospital. What to expect and how to act."

"I keep all the grandchildren and I learned that they are supposed to eat a balanced meal and get their health checked and teeth looked after, too."

"I watch my children more closely. They are so active and don't show early symptoms of their illness."

"I learned that you should pay attention to a child more."

Mental Health

Rationale for choice of topic

An estimated 10% of the people in the U.S. are in need of some kind of mental health care. Perhaps 50% of all medical cases have an emotional component, and economic losses of more than $20 billion a year are attributable to mental illness. These statements reflect a problem of considerable magnitude, yet many people who could benefit from professional help do not obtain it because of its cost, the belief that a stigma is attached to seeking psychological help, and fear or belief that treatment may not be effective.

Behavioral goal

To motivate viewers who feel they may have emotional problems to seek professional help.

Information to convey

1) In many cases, treatment for emotional problems is highly effective.
2) The stigma which formerly was associated with mental illness has diminished greatly in recent years.
3) In some circumstances, professional counseling can be obtained at little or no cost to the individual.
4) Depression is an extremely common condition that is often debilitating. Depression differs from "the blues" in that it lasts longer, may not be associated with a definite cause, and is more severe. Frequent symptoms of depression are loss of concentration, indifference to people and activities formerly seen as important, difficulty sleeping, increased concern about physical condition, and "anhedonia" or the absence of pleasure.

5) Where additional information about mental illness can be obtained.

NOTE: For other goals and content related to mental health, see sections dealing with stress, alcohol abuse, and parenting.

Programming on mental health

Season Program	Segment title	Running Time	Format
A-1	"Depression Sketch"	2:35	comedy sketch
	Two men on a commuter train converse about being depressed.		
A-1	"Helping Hand"	2:53	song
	Johnny Cash does a song which makes the point that one need not be ashamed of seeking help for mental problems (". . . Everybody has his time of trouble, and sometimes it's so hard to understand . . . when all you've got is doubt and no hope of gettin' out, that's the time you need a helping hand . . .").		
A-1	"Davey"	6:40	documentary
	The story of a young auto worker who successfully sought professional help for his personal problems. Segment deals with efficacy of treatment, co-workers' acceptance of Davey's seeking help, and availability of low-cost professional advice.		
A-1	"Johnny Cash Referral"	1:16	lecture/referral
	Johnny Cash gives advice and information about seeking professional psychological help and refers viewers to a source of additional information.		
A-2	"Don't Keep It Inside"	2:22	song
	Jason and Melba, two regular visitors to Mac's Place, do a song about their failure to communicate with each other (". . . When there is something on your mind and it's botherin' you now, don't keep it inside . . . give it to me straight and we're fine . . .").		
A-6	"Someone to Talk To"	2:17	song
	Mel Tillis sings about the need to talk with someone when feeling down (" . . . I wake up mad, go to bed angry, or I'm singin' those pity-me blues . . . that's when I surely could use someone to talk to, who'll help me to find where are my troubles and what's on my mind . . .").		

B-8 "Am I Blue"
(program title)

Dick Cavett as host 1:35 host comments

Cavett provides introduction to segments throughout program and to information referral at end.

"John Smith" 8:38 drama

A man and his family in a home setting depict the symptoms and consequences of depression.

"Dr. Kline Interview" 5:51 interview

Cavett discusses with Dr. Nathan Kline the symptoms and treatment of depression, referring to examples of behavior and feelings shown in the drama preceding the interview. Dr. Kline cites potential sources of help for individuals or families facing a problem with depression.

"Helping Hand" 2:23 song

"Davey" 6:40 documentary

(repeat of segment used in program A-1)

NOTE: Other programming related to mental health is described under the headings of stress, alcohol abuse, and parenting.

Findings. It is difficult to construct items to measure impact in this area because of ambiguities in diagnosing a problem and the variety of behaviors appropriate for dealing with it. At the attitudinal level, NORC asked in Wave 2 for agreement/disagreement with the proposition that a person who goes to a psychologist or psychiatrist to help solve his problems is basically a weak person (Q6-c). There was only weak evidence that Season A programming had any effect on this attitude.

On the behavioral level, RAC asked on the posttest (Q6-a) whether respondents had recently encouraged someone to seek help for an emotional problem. Data analyzed in reference to viewership of program B-8, which dealt with depression and mental health, indicated a suggestive but not

Table 30. MENTAL HEALTH: SUGGESTIVE BEHAVIORAL EFFECTS (RAC)

RAC Posttest Q6-a: Since the last week of March, have you encouraged someone to seek help for an emotional problem?

(all respondents)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-8:	(159)	30	(258)	38	(150)	46
B. View Other Shows:	(378)	30	(703)	24	(378)	28
C. Nonviewers:	(729)	20	(1478)	19	(538)	18
Estimate of Effect = A-B:		0%		14%***		18%***

(college-educated respondents only)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 637)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 1184)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 513)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-8:	(86)	33	(144)	42	(64)	48
B. View Other Shows:	(182)	27	(326)	27	(195)	27
C. Nonviewers:	(369)	22	(714)	20	(254)	21
Estimate of Effect = A-B:		6%		15%**		21%**

** $p < .01$, 2-tail
*** $p < .001$, 2-tail

statistically significant behavioral impact. The impact was consistently greater within the following subgroups: males, college-educated respondents, respondents with 6-17 year-old children, and persons 55 years old and over. In Table 30, one such subgroup, college-educated respondents, is displayed to illustrate the subgroup response pattern.

Conclusions. For both an opinion item and a behavioral item in the mental health area, effects data are suggestive but not clearly demonstrative of an impact.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of mental health:

"I realized after watching the show on depression that I needed help. I learned it's an illness, and treatable."

"I learned of lithium. My wife is now in the hospital testing the same."

"I learned where I could get help for a friend (from the telephone numbers flashed on the screen)."

"I never knew before that the family members were so affected by the depressed member of that family. I thought only the depressed person suffered but I see that others suffer anxiety and can become depressed as a result."

"Depression, what are its signs and effects. In my case, when I lost my job, I was very depressed and didn't know so until I watched that particular show. It gave me the necessary push to 'cross the border.'"

"The show made me feel like there was no reason to be embarrassed if I needed help for depression. If I get a sore throat I go to the doctor so why not go for help if I have depression."

"I learned how common depression was and how symptoms I had felt matched closely those of the businessman in the skit. I also think there was a lot of support for those who might need help."

"There is a member of my family who suffers emotional problems but will not seek help. I was more urged to talk to him about seeing someone with whom he could communicate his feelings after seeing the show on depression and learning that help was available for his particular problem."

"Stop procrastinating and get medical help for an anxiety problem."

"I learned to view depression as more of a disease than I had previously and also now see it as less of a class disease. The garage mechanic's story was very educational."

"It's hard to talk out your problems with someone, but I learned that depression only gets worse if you try to handle it alone."

"I learned to get myself out of depression states because of the show I saw about the man being gloomy and depressed."

Nutrition

Rationale for choice of topic 1 (nutritious snacks for children)

Over-consumption of sugar contributes to obesity and dental disease; much of the excess sugar is consumed in sweet snacks. Nutritious snacks are especially important for children since the food they eat between meals may constitute a substantial part of their total diet.

Behavioral goal 1

To motivate parents and others responsible for child care to give children nutritious snacks.

Information to convey

1) Children consume too much sugar, much of it in the form of sweet snacks.
2) Foods which can provide nutritious snacks for children (e.g., cheeses, nuts, fruits, raw vegetables).
3) Foods which provide non-nutritious snacks (e.g., cupcakes, candy, soft drinks, sugar-coated cereals).
4) Food children eat between meals often constitutes a substantial part of their total diet.
5) Nutritious snacks are often cheaper than candy, cakes, etc.

Rationale for choice of topic 2 (saturated fat)

Medical authorities suggest that a reduction of saturated fat in the American diet would result in reduced risk of heart disease and stroke. In the U.S. today, about 40-45% of the average daily caloric intake is fat.

Behavioral goal 2

To motivate viewers to reduce their excess consumption of foods high in saturated fat.

Information to convey

1) Most people eat too much food containing saturated fat.

2) Foods which are high in saturated fat (e.g., meat, whole milk, butter, egg yolk).

3) Foods which are low in saturated fat (e.g., chicken, turkey, most fish, non-fat milk, cottage cheese).

4) Intake of saturated fat is thought to be associated with increased risk of heart disease.

5) Ways the saturated fat content of meals can be reduced (e.g., cooking with vegetable oils, using egg substitutes and whole milk substitutes, broiling rather than frying, using margarine instead of butter).

Rationale for choice of topic 3 (vitamin A deficiency)

Adequate levels of vitamin A are necessary for maintaining good health in adults and normal growth and development in children. However, recent studies have shown that vitamin A levels are low in many population subgroups, particularly Spanish-Americans and the young.

Behavioral goal 3

To motivate viewers to eat more foods which are sources of vitamin A.

Information to convey

1) Health benefits of maintaining adequate levels of vitamin A (to promote growth, maintain health of eyes and skin, provide resistance to certain bacterial infections).

2) Foods which are good sources of vitamin A (liver, fish, dark green and deep yellow vegetables such as spinach and pumpkin, peaches, raw apricots, etc.).

3) Many foods rich in vitamin A require no preparation (e.g., carrots, cantaloupe, peaches, tomatoes, broccoli, raw apricots).

Rationale for choice of topic 4 (fresh fruits)

Fresh fruits supply the body with vitamin A, vitamin C, and a variety of other necessary nutrients. It is generally agreed that greater consumption of fresh fruit would improve the quality of the American diet, particularly if fruit were substituted for the desserts and snack foods now consumed in large quantities.

Behavioral goal 4

To motivate viewers to eat more fresh fruit.

Information to convey

1) Fresh fruit is a good source of vitamin A, vitamin C, the B vitamins, and other nutrients.
2) Fresh fruits are low in calories.
3) Fresh fruits are easy to prepare.
4) Generally available fresh fruits are apples, bananas, oranges, pears and grapefruit.
5) Fresh fruits can be substituted for less nutritious desserts (e.g., cake, pie, cookies).

Programming on nutrition

Season Program	Segment title	Running Time	Format
A-1	"Bun 'n Run"	:59	parody

In this parody of fast-food restaurant commercials, a smiling family hurries through a meal at "Bun 'n Run". The tag line of the accompanying jingle is "It's not dinner, it's just fun."

A-1 "The Eating Game" 5:08 parody

A take-off on TV game shows; contestants try unsuccessfully to pick a fast-food meal with proper nutrients and caloric values. Information on proper diet and nutrition is provided in comments by the game show host.

A-1 "Steaming Vegetables" and "Too Much of a Good Thing" 4:18 demonstration and song

Blues singer B.B. King demonstrates that steaming is a quick and easy way to prepare vegetables and that it also preserves their nutrient value.

A-4 "Death Row" 3:32 comedy sketch

Charlie Callas portrays a man in Death Row awaiting his last meal. A priest discourages him from eating the sirloin steak, cocoanut cream pie, and other foods because their fat content poses a health risk.

A-4 "Why Keep Fat Out of Your Diet?" 3:07 lecture

Dr. William Lathan discusses ways of obtaining protein without also obtaining a high saturated fat content.

A-4 "Chocolate Bunny" 1:00 "commercial"

Animated take-off on "The Maltese Falcon" in which the Humphrey Bogart character decides to look for fruits rather than tracking down the Chocolate Bunny.

A-5 "Wouldn't You Rather Have a Piece of Fruit?" 2:17 song

Ken Berry does a song about snacking on fruit instead of candy.

A-5 "Permitted Fruit" 5:39 monologue

Bill Cosby does a comedy monologue as a lecturer on fruit eating (from the Garden of Eden to the present).

A-5 "Roadside Stand" 2:48 song

Martin Mull sings a humorous song that tells of a truck driver who keeps "one eye out for highway danger, the other out for fruit".

A-5 "Cornucopia" :48 "commercial"

Visual of a cornucopia with accompanying narration lists chemical ingredients of modern snack foods in the style of a TV commercial for such foods.

A-7 "Morris Katz" 1:39 "commercial"

Parody of cat-food commercial in which a man named Morris Katz is offered a meal from the four basic food groups needed for a proper diet.

A-7 "Eating Game II" 5:54 parody

Parody of TV game show in which a contestant tries to put together a balanced diet from a variety of foods.

A-7 "Algo Poco Differente" 3:43 song

Tito Puente and musical group do a song in Spanish and English which suggest trying something "a little different" in the way of diet.

NOTE: Program B-13, which was devoted entirely to weight control and overeating, was aired after data collection for the evaluation was completed. The program is not described here.

Findings. Statistically significant differences were found for six informational items and for multiple measures of one behavioral item in the nutrition area. Additional items were suggestive of informational or behavioral impact but were not statistically significant because of the magnitude of the observed differences and/or small sample sizes.

There were 9 informational items and 2 behavioral items where the FEELING GOOD series could have had a measurable impact, but did not. Neither significant nor suggestive results were obtained on these items:

1) RAC Interim 1, Q6-b: Cholesterol is found in . . . (eggs and dairy products).
2) NORC Wave 2, Q6-H: Eggs contain a lot of cholesterol (agree). (Also asked, but not analyzed, for NORC Wave 4.)
3) RAC Interim 3, Q5-a: Egg whites contain a lot of cholesterol (mostly disagree).

4) NORC Wave 3, Q4-c (and NORC Wave 4, Q4-i): Eating foods high in cholesterol won't hurt you (disagree).

5) NORC Wave 3, Q4-e: There is a lot of cholesterol in leafy green vegetables (disagree).

6) RAC Interim 3, Q5-b: Which of the following foods are high in cholesterol? (ice cream . . . organ meats)

7) RAC Interim 2, Q5-a: Fruit . . . (contains vitamins and minerals).

8) RAC Interim 1, Q6-c: Meals that you get at fast-food eating places are high in fat and low in vitamin content (mostly agree).

9) RAC Interim 2, Q5-b: Which of these is the most balanced meal? (Meat loaf, mashed potatoes, spinach, roll and butter, and milk)

10) RAC Interim 1, Q1-f (and RAC Interim 3, Q1-f): (In approximately the last two months) have you purposely cut down on eggs, meat, butter or milk because they have a lot of cholesterol? (yes)

11) NORC Wave 3, Q10-b: (Since we last talked with you) have you made an effort to cut down on the amount of cake, cookies, candy and other sweets your children eat? (yes)

Tables 31-33 display significant or suggestive informational and behavioral data, as well as trend data for self-reported behaviors in the nutrition area.

Table 31. SIGNIFICANT OR SUGGESTIVE INFORMATIONAL EFFECTS ON NUTRITION (NORC AND RAC)

NORC Wave 3, Q 4-b: Eggs contain a lot of cholesterol. (agree)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Season A:	Hi Viewer	Lo Viewer	Nonviewer	Nonviewer
	(N=66)	(N=97)	(N=46)	(N=85)
% agree:	91	85	78*	80

NORC Wave 3, Q 4-d: Margarine contains more cholesterol than butter. (disagree)

% disagree:	74	54**	45***	41

NORC Wave 3, Q 4-v: It is good for your health to eat the skin of turkey or chicken. (disagree)

% disagree:	77	55**	54**	70

NORC Wave 2, Q 6-b: It takes less time to steam vegetables than to boil them. (agree)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed
Season A:	Hi Viewer	Lo Viewer	Nonviewer
	(N=46)	(N=63)	(N=24)
% agree:	76	65	46*

Significance of difference from Hi Viewer group: $*p < .05$, $**p < .01$, $***p < .001$

Table 31. (Cont'd.) SIGNIFICANT OR SUGGESTIVE INFORMATIONAL EFFECTS ON NUTRITION (NORC AND RAC)

RAC Interim 1, Q 6-a: Steamed vegetables are better for you than boiled vegetables. (mostly agree)

	Viewers of Show A-1	Viewers of A-2 or A-3	A-1, A-2, A-3 Nonviewers
	(N=83)	(N=43)	(N=392)
% mostly agree:	90	83	76

RAC Interim 3, Q 5-c: It is not healthy to eat chicken skin. (mostly agree)

	Viewers of Show A-9	Viewers of A-10 or A-11	Nonviewers of A-9, A-10, A-11
	(N=68)	(N=33)	(N=246)
% mostly agree:	59	38*	36

RAC Interim 2, Q 5-a: Fruit. . . (helps clean your teeth)

	Viewers of Show A-5	Viewers of A-6,A-7,A-8	Nonviewers of A-5,A-6,A-7,A-8
	(N=69)	(N=54)	(N=328)
% helps clean teeth:	57	38*	40

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* Significantly different from viewers of program A-9 (or A-5), $p < .05$, 2-tail.

Table 32. SIGNIFICANT OR SUGGESTIVE BEHAVIORAL EFFECTS ON NUTRITION (RAC AND NORC)

RAC Interim 2, Q 1-h: Since the middle of November, have you... made a special effort to have more fresh fruit or fruit juice? (yes)

	Viewers of Show A-5 (N=69)	Viewers A-6 - 8 but not 5 (N=54)	Nonviewers (N=328)
% yes:	81	33***	60***

RAC Interim 1, Q 1-m: In the past two months have you used a steamer to cook your vegetables? (yes)

	Viewers of Show A-1 (N=83)	Viewers A-2 - A-3 but not 1 (N=43)	Nonviewers (N=392)
% yes:	29	25	21

NORC Wave 2, Q 1-h: Since the last time we talked, have you made a special effort to eat fresh fruit? (yes)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed
Season A viewing:	Hi Viewer (N=46)	Lo Viewer (N=63)	Nonviewer (N=24)
% yes:	70	66	42*

NORC Wave 3, Q 6-b: Since the middle of November/December, have you made a special effort to eat fresh fruit? (yes)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Season A:	Hi Viewer (N=66)	Lo Viewer (N=97)	Nonviewer (N=46)	Nonviewer (N=85)
% yes:	70	83	52*	58

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*Significantly different from Hi Viewer group, $p < .05$, 1-tail.

***Significantly different from viewers of show A-5, $p < .001$, 2-tail.

Table 33. TRENDS IN SELF-REPORTED NUTRITIONAL BEHAVIORS (GALLUP AND RAC)

Gallup Survey #:	1	2	3	3	4	4
Field date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for past 2 months only:	X	X	X		X	
Q asked for past 6 then 2 months:				X		X
Base N:	(1517)	(1544)	(785)	(814)	(799)	(826)
Made special effort to have more fruit or juice? % yes:	38	36	NA	NA	NA	NA
Cut down on cake, cookies, candies, etc. that your children eat? % yes:	50	41	NA	NA	NA	NA
(N parents)	(735)	(721)				
Cut down on eggs, meat, butter, or milk? % yes:	30	26	28- -	-17	29- - -	-19

RAC Interim Measure #:	1	2	3
Field date:	12/74	1/75	3/75
Time reference for Q: Since middle of.	October	November	December
Base N (all respondents):	(518)	(466)	(411)
Have you purposely cut down on eggs, meat, butter or milk because they have a lot of cholesterol in them? % yes:	33	39	35
Have you made a special effort to have more fresh fruit or fruit juice? % yes:	62	60	66

Conclusions. Nutritional themes that appeared in both the series and the evaluation program included the desirability of reducing cholesterol intake and increasing consumption of fruits and vegetables, reducing sweets in children's snacks, and preparing foods to preserve nutrients. On the cholesterol reduction theme, the series was only partially successful in increasing the awareness of the high cholesterol content in egg yolks. However, the series was credited with increasing knowledge that chicken or turkey skins should be avoided, and that butter is higher in cholesterol than margarine. This did not translate into behavior change, however. Evaluative measures on the food preparation theme were restricted to RAC and NORC interim measures, where small samples made it very difficult to demonstrate statistically significant differences. Nevertheless, changes in awareness of reasons for steaming vegetables registered as statistically significant in one case and suggestive in another. On a nutrition-related theme, there was evidence of learning that eating fruit can help clean one's teeth. There was also some evidence that viewing the series led respondents to increase their intake of fresh fruit. Outside the domain of formally structured evaluation items, it should be noted that the NORC respondents induced to view and be interviewed (Treatment Group A) were asked in Wave 4: "Have you done anything new or anything differently as a result of watching FEELING GOOD?" The free responses of self-reported and self-assessed behavioral impact elicited by this question fell predominantly into the nutrition category.

Weight Control

Dietary aspects of weight control are closely related to the area of nutrition. The series had no behavioral goals pertaining to weight reduction, but the evaluation included questions to assess possible ancillary effects of programming on related topics.

Findings. Only three items were relevant to dietary aspects of weight control. RAC Interim 1 Q5-a asked which of several options was a good weight control program; 83% of the 518 respondents selected 'to get more exercise and eat less," and no differential viewing impact could be detected. Trend data from RAC and Gallup on the incidence of starting a diet to lose weight are displayed in Table 34.

Conclusions. No series impact was expected or demonstrated in the area of weight control.

Table 34. WEIGHT CONTROL: DESCRIPTIVE TREND DATA ON STARTING DIETS TO LOSE WEIGHT (RAC AND GALLUP)

Item: (In the last two months, have you . .) started a diet to lose weight?

Gallup Survey #:	1	2	3	3	4	4
Field Date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for 2 mos. only:	X	X	X		X	
Q asked first for 2 then 6 mos.:				X		X
Base N:	(1517)	(1544)	(785)	(814)	(799)	(826)
% yes:	28	24	27 - - -	18	32 - - -	20

RAC Interim:	1	2	3	3 (Panel Control)
Field date:	12/74	1/75	3/75	3/75
Base N:	(518)	(466)	(411)	(353)
% yes:	38	44	37	45

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of nutrition:

"We all started watching our diets much closer to make sure we were getting daily doses of the vitamins needed and exercises were started up, once again!"

"I have tried to prepare the right meals and to encourage my husband to exercise in moderation."

"I was not aware of the extremely low nutritional value of foods at 'fast food joints.'"

"Since January I've lost ten pounds and I made myself do something -- and it was the result of watching your program."

"I've started weighing myself daily and when I get five pounds over I start doing something about it."

"I'm losing weight and say your show helped me realize overweight is not good. I watch my diet more and do more exercise."

"I learned about cooking vegetables and keep nourishment to a maximum."

"I watched the number of eggs we eat and the eyes and try to eat more carrots and try to see that they (kids) get rest and proper exercise. I did cut down bread and bacon and fatty foods. Put in more vegetables, raw carrots in salad and cut down on sweets a lot."

"I now skin a chicken before cooking it."

"I learned about calories and the value of foods to the body and what different foods do to your body."

"I now shop for vegetables and meats instead of instant stuff."

"Now I give my little girls fruit instead of candy."

Breast Cancer

Rationale for choice of topic

Breast cancer is the most common cancer and the leading cause of death from cancer among women. About 7% develop the disease at some time in their lives; in 1973 alone, there were an estimated 74,000 new cases and 33,000 deaths from breast cancer in the U.S. However, the survival rate is very high (85-90% at five years) when the disease is detected and treated at an early stage.

Surveys show that most women know about breast self-examination (BSE) but that only 23% do a BSE monthly. The reasons most often given for not performing a BSE regularly are ignorance of the importance of the examination, a feeling that it would cause unnecessary worry, and a lack of confidence in doing a BSE effectively.

Behavioral goals

1) To motivate women to ask a doctor or nurse to teach them how to do a BSE.
2) To motivate women to do a BSE monthly.
3) To motivate viewers to encourage others (friend, spouse, etc.) to do a BSE monthly.

Information to convey

1) The best way to learn BSE is to have a doctor or nurse teach you.
2) BSE is a simple procedure to learn and practice.
3) Women who have been taught BSE by a doctor or nurse are more confident of their ability to do it effectively.
4) BSE should be done monthly.

5) Most breast lumps (65-80%) detected through BSE are not malignant.

6) Early detection of malignancies greatly increases the likelihood of successful treatment, as evidenced by high survival rates.

7) Any lump found in a BSE should be checked by a doctor.

8) Treatment of breast cancer by mastectomy need not preclude resumption of a full range of normal activities.

Programming on Breast Cancer

Season Program	Segment title	Running Time	Format
A-3	"A Family's Story"	8:05	documentary
	A woman and her family tell about their experience with breast cancer--its detection, treatment through surgery, and recovery. Comments deal candidly with fears of death and loss of attractiveness, and why most are unwarranted.		
A-3	"Celebrate"	2:10	song
	Ethel Shutta portrays an older woman singing about the joys of living.		
A-3	"Breast Self-Examination"	3:08	demonstration
	A woman doctor shows a patient how to do a breast self-examination. Narration points out that breast lumps are quite common but that most are benign.		
B-5	"Cavett/Child Interview"	8:04	interview
	Dick Cavett interviews Julia Child about her own experience with breast cancer. Discussion also covers common miscondeptions regarding the prevalence and seriousness of breast cancer and the consequences of mastectomy.		
B-5	"Breast Essay"	2:05	film montage
	Illustrated commentary concerning how women feel about their breasts as they grow up.		
B-5	"Breast Self-Examination"	4:51	demonstration
	A woman doctor shows a patient how to do a breast self-		

examination. Narration covers reasons for performing such examination regularly.

B-5 "Sketches--No Time" 1:37 comedy sketches

Three brief monologues by women who give excuses for not doing breast self-examination (being too busy, worrying too much, etc.).

B-5 "A Family's Story" 8:01 documentary

A woman and her family tell about their experience with breast cancer. (Repeat of segment used in program A-3)

Findings. Tables 35 and 36 present baseline data concerning breast cancer. In both the RAC and NORC studies, three-fourths of the respondents were aware that the chance of recovery is very good if breast cancer is detected and treated early. More than 80% had heard of breast self-examination, and about 45% of women who had examined their breasts said that they had learned the technique from a doctor or nurse. Slightly more than half of the women in both studies reported having a breast examination by a doctor on an annual basis, and about one-fourth claimed to have had such an examination in the past three months. Of the NORC respondents who reported having examined their own breasts at some time, 32% said they had first done so within the last year.

Three knowledge/opinion items and three behavioral items asked on the RAC posttest and intended to measure effects of viewing produced neither significant nor suggestive evidence of impact regarding breast cancer. These items were:

- About what proportion of women will develop breast cancer? (Q14-a)
- The likelihood of breast cancer increases with . . . (age). (Q14-c)
- After a woman has had a breast removed, she can still have a normal sex life. (Q14-f)

Table 35. BASELINE KNOWLEDGE/OPINIONS ON BREAST CANCER (RAC AND NORC)

[common wording, both studies]
If breast cancer is detected early, do you think the chance of recovery is. .

	NORC BASELINE (N=398) Baseline Q 28 %	RAC BASELINE (N=5,063) Baseline Q 9 %
very good	77	76
fair	18	16
poor	3	1
don't know	2	6 (incl. no answer)
	Q 24: Have you ever heard of Breast Self-Examination - - where a woman examines her own breasts for the presence of lumps? (N=400)	Q 26-a: Do you know how to examine your own breasts for lumps, without the help of a doctor or anyone else? (Weighted N = 8141 women)
yes (%)	88	83
	Q 26: How did you first learn to examine your own breasts? (Base = 296 women who have examined their own breasts)	Q 26-b: How did you learn to examine your own breasts for lumps? (Base = weighted N of 8141 women)
	from a doctor: 40% from a nurse: 4	doctor or nurse showed me how: 46%
	from a magazine: 15	from magazine, newspaper or leaflet: 21
	from television: 14	from television: 13
	from a friend: 3	from a friend: 1

Table 36. BASELINE BEHAVIORS RELEVANT TO BREAST CANCER (RAC AND NORC)

	NORC BASELINE	RAC BASELINE
	Q 23: Did a doctor ever examine your breasts for the presence of lumps? (Base = 400 [women]) Yes: 84%	Q 25: Has a doctor ever examined your breasts for lumps? (Base = 3,622 women) Yes: 91%
	(Base = 337 saying "yes" above)	(Base = 3,296 women saying "yes" above)
When was the last time?	Q 23-a	Q 25-b
...within last 3 months:	27%	26%
...between 3 and 6 mo. ago:	18	22
...between 6 months and a year ago:	32	27
...between 1 and 2 years ago:	12	15
...longer than that [more than 2 years ago] :	10	10
In general [usually] , how often do you have [does] a doctor examine your breasts?		
	(Q 23-b; Base = 335 saying "yes" to Q 23)	(Q 25-c; base = 3,296 women saying "yes" to Q 25)
...every 3 months:	2%	1%
...every 6 months:	19	17
...every year:	56	56
...every 2 years:	4	4
...less often than that [less than every 2 yrs.]:	8	2
...no regular time:	10	17
...don't know:	1	
...[not reported] :		3

NORC Q 25: Did you ever examine your own breasts for the presence of lumps?
(Base = 350)
...yes: 84%

NORC Q 25-a, asked of 296 women saying "yes" above: When did you start examining your breasts -- was it...

...within the last 3 months:	13%
...between 3 and 6 mos. ago:	7
...between 6 months and a year ago:	12
...between a year and 2 years ago:	17
...longer ago than that:	50

- When was the last time a doctor examined your breasts for lumps? (Q36)
- When was the last time you examined your own breasts for lumps? (Q37)
- In the last six months, did you try to get information on any of the following subjects for yourself or someone else? . . . (how to do a breast examination for women) (Q5-f)

A behavioral item used by NORC on Wave 2 (Q1-f) and repeated on Wave 3 (Q6-g) produced results which were not significant or clearly suggestive on either wave. The item was:

- Have you asked a doctor to teach you how to examine your own breasts since we last talked with you?

However, significant or suggestive evidence of effects was found on a number of other items. The data are presented in Tables 37 through 45. To provide a context for interpreting the NORC and RAC data, findings from the four Gallup surveys are included in Table 46. A statement of conclusions follows the tables.

As described earlier, the Gallup Organization conducted four national surveys to provide trend data. Among behaviors checked repeatedly were breast self-examinations and breast examinations by a doctor within the preceding two months (female respondents). Data from the first two Gallup surveys appeared to be inflated on these behavioral self-reports, probably reflecting inflationary influences of telescoping by respondents: i.e., reporting actions taken more than two months earlier as having occurred within the preceding two months. For the last two national surveys, therefore, Gallup built an experiment into the interviews: half the respondents were asked the behavioral checklist items as before (referenced to the preceding two months); the other half were first asked the questions in reference to the last six months, then again for the last two months. The rationale was that the tendency to telescope would be expended in reference to the six-month interval, making the same question far freer of that inflation when later asked for the preceding two months. There were definite and uniform indications that self-reported health behaviors referenced to the last two months were indeed higher (by about 10%) when asked directly than when preceded by an initial self-report referenced to the last six months. Gallup concluded: "The responses of those who were first asked about the six-month period provide a good estimate of the proportion of all adults who actually took each health step within the past two months" (Gallup, Volume IV, p. 14).

Self-report data on these same two breast cancer-related behaviors were much higher in RAC's four-city study than in the Gallup surveys. Even with the population and methodological differences between the two studies, the RAC self-report behavioral data appear inflated beyond the inflated level of the Gallup data. This probable inflation is pointed out in the RAC report, but with the conclusion that this did not affect the relative standing of various respondent subgroups. The behavioral self-reports in the RAC and NORC studies were intended to provide an estimate of relative effects among various levels of viewership. The self-reports provided by the last two Gallup surveys presumably are more accurate as indicators of specified health behaviors in the general adult population.

Table 46 presents the relevant data from Gallup waves 1-4, RAC interim measures 1-3, and NORC waves 2 and 3.

Table 37. BREAST CANCER: DESCRIPTIVE KNOWLEDGE AND OPINION DATA (RAC AND NORC)

RAC Interim I	Viewers of Show A3 (N = 64)	Nonviewers of Shows A1 - A4 (N = 377)
RAC Q 8-a: Women should examine their breasts for lumps - -	%	%
- - every month:	66	58
RAC Q 8-b: If discovered early, most breast cancer can be controlled - -		
- - mostly agree:	99	94
RAC Q 8-c: A lump in the breast almost always means a woman has cancer - -		
- - mostly disagree	91	79

NORC treatment group:	TREATMENT GROUP A Induced to view and be interviewed		TREATMENT GROUP B Induced to be interviewed
Viewing level:	High	Low	Nonviewer
Subsample size:	(N=46)	(N=63)	(N=24)
NORC Wave 2, Q 8: If breast cancer is detected early, do you think the chance of recovery is - - very good:	89%	78%	88%

Table 38. BREAST CANCER: BEHAVIORAL EFFECTS IN SEASON A (RAC)

RAC Interim I, referenced to "Since the middle of October," Q 2-r: (Have you) had a breast examination by a doctor? Q 2-s: Examined your own breasts for lumps? (Based on women only)

	All Respondants (N = 378)	Viewers of A3 (N = 52)	Viewers of A1, A2, A4 (N = 50)	Nonviewers (N = 276)
Q 2-r (Dr. examined breasts) yes:	30%	21%	22%	32%
Q 2-s (Examined own breasts) yes:	75%	87%	64%*	75%

* Significantly different from A-3 viewers $p < .05$, 2-tail.

Table 39. BREAST CANCER: BEHAVIORAL EFFECTS IN SEASON A (NORC)

NORC Wave 2, Q 1-d, and Wave 3, Q 6-e: Since we last talked with you, have you had a doctor examine your breasts?

NORC Wave 2, Q 1-e, and Wave 3, Q 6-f: Have you examined your own breasts?

Treatment Group:	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Viewing Level:	High	Low	Nonviewer	Nonviewer
N, Wave 2:	(46)	(63)	(24)	
N, Wave 3:	(66)	(97)	(46)	(85)
Has doctor examined breasts since last interview?				
Wave 2:	13%	13%	8%	
Wave 3:	38%	38%	26%	38%
Have you examined your own breasts since last interview?				
Wave 2:	80%	68%	54%*	
Wave 3:	80%	85%	57%**	60%

Significantly different from high viewer group, *p <.05, 1-tailed test; **p <.01, 1-tailed test.

Table 40. BREAST CANCER KNOWLEDGE EFFECTS IN SEASON B (NORC)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Program B-5 Viewing Status:	Viewer (N=91)	Nonviewer (N=146)	Nonviewer (N=103)	Nonviewer (N=84)
NORC Wave 4, Item 4-e: After a woman has had a breast removed because of cancer, she is still capable of having a normal sex life. (agree)	98%	96%	88% **	88%
NORC Wave 4, Q 11: How often do you think a woman should examine her own breasts for lumps? (every month)	75%	61%*	51%***	48%
NORC Wave 4, Q 12: Even with early detection and treatment, a large majority of women with breast cancer die from it. (disagree)	88%	79%	68%***	64%

Statistically significant differences from the viewer group:
* p< .05, 1-tail
** p< .01, 1-tail
*** p< .001, 1-tail

Table 41. BREAST CANCER: PROGRAM B-5 KNOWLEDGE EFFECTS (RAC)

RAC Posttest Q14-b: Out of 100 women who discover a lump in their breast, how many of them turn out to be cancer? ("about 15" or "about 25")

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-5:	(266)	28	(505)	27	(303)	28
B. View Other Shows:	(271)	17	(456)	20	(225)	26
C. Nonviewers:	(729)	18	(1478)	20	(538)	17
Estimate of Effect=A-B:		11% ***		7%*		2%

***P < .001, 2-tail * P < .05, 2-tail

Table 42. BREAST CANCER: SEASON B KNOWLEDGE EFFECTS (RAC)

RAC Posttest Q 14-d: How often should women examine their breasts for lumps? (every month)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		REPEATED MEASURE RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-5:	(266)	66	(505)	69	(303)	63
B. View Other Shows:	(271)	58	(456)	62	(225)	59
C. Nonviewers:	(729)	60	(1478)	64	(538)	61
Estimate of Effect=A-B:		8%		7%		4%

PRE-POST ANALYSES	INTRA-GROUP COMPARISONS FOR SEASON B PRE to POST EFFECTS (group 2 above, pre to post)				
	B-Pre:	+	+	-	-
	B-Post:	+	-	+	-
	Base N	%	%	%	%
A. View Show B-5:	(503)	51	6	18	25
B. View Other Shows:	(456)	50	12	12	27
C. Nonviewers:	(1475)	50	10	14	26

Definition of Effect Estimate: Subtract % "backsliders" (Pre+, Post-) from % "converts" (Pre-, Post+) for viewing levels A, B and C. Then, Effect = (A-C) - (B-C) = A-B.

Estimate of Effect: (pre to post gain) 12%*

* P < .05, 2-tail

Table 43. BREAST CANCER: SEASON B KNOWLEDGE EFFECTS (RAC)

RAC Posttest Q14-e: Even with early detection and treatment, a large majority of women with breast cancer never recover from it. (mostly false)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-5:	(266)	87	(505)	84	(303)	78
B. View Other Shows:	(271)	85	(456)	82	(225)	75
C. Nonviewers:	(729)	82	(1478)	83	(538)	77
Estimate of Effect=A-B:		2%		2%		3%

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PRE-POST ANALYSES	INTRA-GROUP COMPARISONS FOR SEASON B PRE to POST EFFECTS (group 2 above, pre to post)				
	B-Pre:	+	+	-	-
	B-Post	+	-	+	-
	Base N	%	%	%	%
A. View Show B-5:	(503)	71	7	12	10
B. View Other Shows:	(456)	73	11	8	7
C. Nonviewers:	(1475)	71	10	11	7

Definition of Effect Estimate: Subtract % "backsliders" (Pre+, Post-) from % "converts" (Pre-, Post+) for viewing levels A, B, and C. Then, Effect = (A-C)-(B-C) = A-B.

Estimate of Effect: (pre to post gain) 8%*

*p < .05, 2-tail

Table 44. BREAST CANCER: PROGRAM B-5 BEHAVIORAL EFFECTS (RAC)

RAC Posttest Q6-e: Since the last week of March, have you suggested to a friend or relative of yours that she have a doctor examine her breasts? (yes)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-5:	(266)	29	(505)	24	(303)	26
B. View Other Shows:	(271)	20	(456)	17	(225)	13
C. Nonviewers:	(729)	10	(1478)	13	(538)	11
Estimate of Effect=A-B:		9*		7*		13*

*P < .05, 2-tail

Table 45. BREAST CANCER: SEASON B
BEHAVIORAL EFFECTS (NORC)

NORC Wave 4, Item 25. Did you ever examine your own breasts for the presence of lumps? (yes)

	TREATMENT GROUP A Induced to View and be interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
	Viewer	Nonviewer	Nonviewer	Nonviewer
Program B-5:	(N=91)	(N=146)	(N=103)	(N=84)
% yes:	98	93	87**	81

Item 25-a: [If Yes] When did you start examining your breasts -- was it... (within the last 3 months)?

	(N=89)	(N=134)	(N=90)	(N=67)
% within last 3 mos.:	15	9	3**	9
3-6 mos.:	10	13	2*	3
6 mos.-1 yr.:	25	23	14*	16

Item 25-b [If Yes to Item 25]: How did you first learn to examine your breasts?

	(N=89)	(N=134)	(N=91)	(N=68)
..From TV:	40%	27*	7***	12
..Doctor:	25	37	43	48
..Magazine:	8	13	14	18

Significance of difference from the viewer group:
*$p < .05$
**$p < .01$
***$p < .001$

Table 46. TRENDS IN SELF-REPORTED BREAST EXAMINATIONS (Gallup, RAC AND NORC)

Gallup Survey #:	1	2	3	3	4	4
Field date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for past 2 months only:	X	X	X		X	
Q asked for past 6 then 2 months:				X		X
Base N:	(768)	(765)	(387)	(412)	(407)	(417)
Breast self-examination reported:	51%	38%	40%----	----29%	46%------	------36%
Breast examination by doctor reported:	32%	26%	33%----	----19%	32%------	------20%

RAC Interim Measure #:	1	2	3
Field date:	12/74	1/75	3/75
Time reference for item: Since the middle of . . .	October	November	December
Base N (all female respondents):	(378)	(338)	(297)
Breast self-examination reported:	75%	72%	74%
Breast examination by doctor reported:	30%	36%	31%

NORC Wave:	2	3
Field date:	12/74	2/75
Time reference for item: Since. . .	11/74	12/74 for Wave 2 Rs. 11/74 for others
Base N (all respondents):	(135/134)	(309)
Breast self-examination reported:	70%	74%
Breast examination by doctor reported:	13%	37%

Conclusions. Before the series began, three-fourths of the respondents in the RAC and NORC studies felt that chances of recovery from breast cancer were very good when it was detected early; breast self-examination (BSE) was a familiar concept to over 80%; and television was cited by 13-14% as the respondent's source of information about BSE (Table 35).

The series did have certain positive effects with regard to breast cancer. RAC female respondents who viewed program A-3, which treated this topic, reported in significantly greater proportions a breast self-examination since the middle of October, 1974, than did nonviewers or viewers of other shows (Table 38). NORC respondents who were high viewers of Season A programming (therefore more likely to have seen program A-3) reported in greater proportions that they had recently done a breast self-examination (Table 39). No other impact on knowledge or opinion was attributable to program A-3, or to Season A programming in general, on the subject of breast cancer: e.g., optimum frequency of conducting BSEs, chances of recovery from breast cancer, the ability to control breast cancer, or the probability that a lump means cancer.

After program B-5 also treated the topic of breast cancer, both the RAC and NORC studies detected two knowledge/opinion effects: (1) an increase in the proportions reporting that breast self-examinations should be conducted every month (Table 42 for RAC; Table 40 for NORC); and (2) an increase in the proportions reporting that the chances of recovery from breast cancer are good, given early detection and treatment (Table 43 for RAC; Table 40 for NORC). Ceiling effects in both studies made it difficult for the program to increase the proportion of viewers believing that a woman is capable of a normal sex life after breast removal, but even so the NORC study showed partial evidence for a viewing effect on this item (Table 40).

Behavioral effects attributed to program B-5 include the following:

1) An increase in the proportion reporting that they had recently suggested breast examination to a friend or relative (RAC study, Table 44).
2) An increase in the proportion reporting previous breast self-examinations and recent initiation of breast self-examinations (NORC study, Table 45).
3) An increase in the proportion reporting that they learned how to do a breast self-examination from television (NORC study, Table 45).

There was no detectable effect of program B-5 on reported incidence of breast examinations by a doctor or in breast self-examinations. Comparisons of RAC and NORC trend data with Gallup trend data (Table 46) indicated probable inflation in absolute terms of these and other self-reported health behaviors; however, the relative proportions among various viewing/non-viewing groups remain interpretable.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of breast cancer:

"The program made me examine my breasts more closely and sure enough I did detect a lump on my left breast. I immediately called a doctor next morning and within a week was operated on. By acting so quickly the lump was localized and had not spread much, but it was malignant. This was three weeks ago. I'm fine now."

"Somehow the subject of breast cancer seems to me now less frightening than it used to be."

"The preventative cancer methods are effective and I've learned to at least examine myself for breast cancer."

"My wife is going to the Virginia Mason Clinic in Seattle on July 11th for a breast cancer check."

"I learned what to look for in my breast. Before I really didn't understand how to check myself."

"I learned that breast cancer was nothing to be afraid about. I learned that some women die and some don't."

"I learned how one can live an active life even with a mastectomy."

"After watching the show I discussed breast examinations with my fiancee."

"I learned how simple it is to check for breast cancer. I'm one of the lucky ones to have found out that a lump doesn't always mean cancer."

"I learned the effects of a mastectomy need not alter the course of a woman's life."

"I learned more about giving myself breast checks and how important the examinations are. I learned a lot more about it. I also learned more about the chances of recovery."

Accident Prevention and Control, and Medical Emergencies

Rationale for choice of topic 1 (accidental poisoning)

About 700,000 accidental poisonings occur annually in the U.S. In one year, 84,000 of these accidents involved children under five years of age, with toddlers aged one to three affected most often. Since children of this age may be unable to distinguish hazardous substances, the most effective means of preventing accidental poisonings is to make such substances inaccessible to children. Local poison control centers can provide information about potentially hazardous substances as well as treatment when accidental ingestion occurs.

Behavioral goals

1) To motivate viewers to store potentially hazardous substances out of the reach of children.
2) To motivate viewers to find out the number and location of the nearest poison control center (and other emergency numbers).

Information to convey

1) Ingestion of medicines (such as aspirin) is the most common cause of accidental poisoning for children aged 1-5.
2) The kitchen is the most common site of poisoning accidents.
3) The likelihood of accidental poisoning of children is reduced by storing medicines and household cleaners in high cupboards, locked cabinets, or on high closet shelves rather than under the kitchen sink.
4) Poison control centers provide information about possible poisons, their effects, antidotes, and treatments.

5) Having the number of the poison control center handy can save critical time in an emergency.

Rationale for choice of topic 2 (burns)

About 91,000 injuries each year are caused by home fires, and as many as 975,000 people are injured by contact with hot objects, corrosive substances, steam or open flames. Fires and burns are the leading cause of death from home accidents to children 1-4 years old.

Behavioral goal

To motivate viewers to avoid circumstances which commonly lead to burn injuries.

Information to convey

1) Burn injuries can result from smoking in bed or improper disposal of cigarettes, leaving matches or appliance cords within children's reach, and improper storage or use of flammable materials.
2) The likelihood of burn injuries to children can be reduced by keeping the home free of potential fire hazards; not leaving unattended a hot iron, heater, stove, or other source of heat when children are present; and using non-flammable clothing whenever possible.

Programming on accident prevention and control

Season Program	Segment title	Running Time	Format
A-1, A-4, A-10	"Fred Smokes in Bed"	1:26	"commercial"

Middle-aged Fred is shown smoking and coughing in bed. At the end, narration by his wife notes "That's why he sleeps down at the firehouse," and Fred's bed is shown to be in the driveway of a fire station. Narrator and graphic convey the message that "Smoking can be hazardous to your house, too."

A-1, A-5 "Baby Annie" 1:00 "commercial"

In this animated spot, a small boy playing doctor gives his smaller sister a dozen aspirin. A quick trip to the hospital follows, and the next time the children want to play doctor they find the medicine is all locked up.

A-5 "Medical Emergencies" :33 vox pop

People on the street tell what they think they would do in the case of a medical emergency.

A-5 "Common Emergencies" 3:26 lecture/demonstration

Dr. Timothy Johnson discusses the basic steps in dealing with children's cuts and shows how to apply a bandage to a cut on a boy's leg.

A-5 "Poison Control" :29 vox pop

Four women responding to a question discover that they don't know the poison control telephone number in their community.

A-5 "Case of the Red Ink" 4:05 comedy sketch

The climactic scene in a murder mystery involving a police lieutenant and three strange suspects. The case turns on the alteration of a poison control number by the telephone.

A-5 "Mac's Place segments" 11:36 situation comedy/drama

Five-year-old Felipe is taken to the hospital in a hurry when everyone thinks he has swallowed some cleaning fluid kept in the back of Mac's store.

A-5 "Darling Be Careful" 2:00 song

Rita, Felipe's mother and a waitress at Mac's Place, is relieved to learn that her son is all right (see preceding segment). Rita sings to Felipe (". . . So darling be careful, whatever you do . . . it's so important, I worry for you now . . . whatever you do, I love you . . .").

A-8 "Marty's Mother" 4:30 comedy sketch

Mrs. Leshner, played by Anne Meara, is preparing for a dinner and finds that her oven won't light. Trying to call the gas company, she phones the Suicide Prevention Center by mistake and carries on a conversation with a doctor there unaware that she has the wrong number.

A-8 "Emergencies" :33 vox pop

Several people tell what they would do and where they would go in case of a medical emergency.

A-8 "The Good Scout" 4:29 comedy sketch/ song

Arte Johnson, as a Boy Scout, demonstrates through a song how one can help in a medical emergency by getting all the important information and then informing the telephone operator.

A-11 "Burns" 3:35 film montage

Segment opens with humorous clips from silent movies illustrating situations involving burn accidents. Later, visuals and narration give specific advice concerning actions to take or avoid in treating a burn injury.

A-11 "Nosy Neighbor" 1:36 song

Martin Mull sings about a next-door neighbor who is constantly checking for fire hazards (". . . She checks the oven and the toaster . . . checks the plugs on all the wires . . . she reads the labels on our clothes . . . and if it burns, out it goes . . .").

NOTE: Other programming on medical emergencies is described in the section on heart disease.

Findings. Several preseries baseline measures are of general interest, and are presented here for descriptive purposes. In the NORC baseline survey, 399 women were asked: If a child in your house accidentally swallowed some medicine not prescribed for him, or some cleaning fluid, what is the very first thing you would do? Responses were:

. . . call a doctor (30%)

. . . make him throw up (16%)

. . . take him to a doctor (15%)

. . . take him to an emergency room/hospital (10%)

. . . give him milk or water (9%)

. . . telephone the poison control center (2%)

. . . (unspecified other, 18%) (NORC Baseline Q39)

Among a weighted sample size of 3,210 parents of children under six, (unweighted N not reported) 62% claimed that all the medicines and household cleaners were kept out of children's reach; 32% claimed that some of them were (RAC Baseline, Q18).

RAC Interim 2, Q7-b did not establish a relationship between viewing Season A programming and the pattern of responses, so those overall data are provided for descriptive purposes also: What is the best way to control bleeding from a cut? (overall N = 466)

. . . raise cut above head and apply iodine or other antiseptic (2%)

. . . tie a tourniquet or tight bandage between cut and heart (25%)

. . . apply pressure with clean cloth for 10 minutes (58%)

. . . wash out cut with water and let bleed to prevent infection (5%)

. . . none of these (1%), don't know (8%)

Season A programming had no statistically significant or suggestive effects on knowledge of emergency treatment for burns (RAC Interim 3, Q11 and 11-b). Measures taken during and after Season A showed no clear impact on the proportions claiming to have recently made special efforts to place harmful materials out of children's reach (NORC Wave 2, Q2-a; NORC Wave 3, Q10-a; a suggestive but not statistically significant effect was found in RAC Interim 2, Q1-j).

A major behavioral goal in this topic area was to get people to place the number of the local poison control center near their telephone. There were indications of successful impact here on several measures: as analyzed by impact of program A-5, as analyzed by overall frequency of viewing Season A, and as analyzed by overall frequency of viewing the series as a whole on pretest to posttest comparisons. These data are displayed in Tables 47 and 48.

Table 47. ACCIDENT PREVENTION: SEASON A BEHAVIORAL EFFECTS ON POSTING THE POISON CONTROL CENTER NUMBER (NORC AND RAC)

NORC Wave 3, Q7: Do you have the telephone number of the Poison Control Center written down somewhere?

	TREATMENT GROUP A Induced to view & be interviewed		TREATMENT GROUP B Induced to be interviewed	TREATMENT GROUP C No Inducement
Season A:	High Viewer (N = 32)	Low Viewer (N = 54)	Non-viewer (N = 28)	Non-viewer (N = 44)
% yes:	37	20	7**	9

**Significantly different from High Viewer group, p. < .01 1-tail.

RAC Interim 2, Q1-e: In the last 2 months, have you placed the number of the local poison control center near your phone?

	Viewed Program A-5 (N = 69)	Viewed A-6-8 but not 5 (N = 54)	A-5-8 Nonviewer (N = 328)
% yes:	31	14*	16

*Significantly different from Viewers of Program A-5, p < .05, 2-tail.

Table 48. ACCIDENT PREVENTION: PRETEST-POSTTEST COMPARISONS OF OVERALL SERIES IMPACT ON POSTING THE POISON CONTROL CENTER NUMBER NEAR THE TELEPHONE (RAC)

RAC Baseline Q7-a: Are these telephone numbers written down and posted near your telephone?

. . . the poison control center in your area
1-yes
2-no
3-not sure

RAC Posttest Q10: Do you have the telephone number of the poison control center for your area posted near your telephone?
1-yes
2-no

	Base N = number checking "no" or "not sure" on the preseries baseline	Proportion of Base N checking "yes" on the Posttest
	N	%
Hi Viewers (viewed 4 or more shows in the entire series):	(513)	30
Lo Viewers (viewed 1-3 shows in the entire series):	(698)	25*
Nonviewers (viewed no shows in the entire series):	(1,422)	22***

Significance of difference from the High Viewers: $*p < .05$, 2-tail; $***p < .001$, 2-tail.

Conclusions. As assessed in relation to viewing of specific Season A programs and to viewing levels for the entire series, FEELING GOOD had a significant behavioral impact on the proportions reporting the posting of the number of the local poison control center near the telephone. There was no demonstrated effect on knowledge of emergency treatment for burns, and only suggestive evidence of increased efforts to remove harmful substances from children's reach.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of accident prevention and control:

"After watching the show my ten year old son posted the poison control number beside the telephone."

"I thought the episode on poisoning very helpful. Since then I have made sure that everything is stored properly, marked clearly, and out of children's reach."

"I've been more careful with my baby. I put everything up higher."

"I keep my detergent out in the garage away from my child."

"The poison show reminded me that even though my kids are six and four, they can still get into things and it's dangerous to have all that stuff down in their reach. Cleaning supplies and different chemicals and bleach, now I've got them put away."

"I try to keep medicine bottles closed tightly and out of reach of the children."

"I learned a better way to handle emergencies with your children as poison prevention. I feel like I could take care of an emergency when before I didn't think I could even think straight."

"I've put safety caps on most of my things and I learned that. And I used to put my bleach and detergent under the sink and I learned it doesn't have to go there so now I put it on top."

"I've written down all my emergency numbers."

Doctor/Patient Communication and Patients' Rights

Rationale for choice of topic 1 (patient questions)

There is considerable evidence that poor communication between doctors and patients is widespread. For a variety of reasons--awe of the physician, fear of appearing ignorant, fear of hearing bad news about illness, and awareness that doctors are busy--many patients fail to ask questions about the meaning of symptoms or the basis for recommended actions. Doctors' advice and recommendations are frequently so unclear to patients that recovery is impeded. Several studies have shown that physicians tend to overestimate patients' understanding of their advice.

Behavioral goal

To motivate viewers to question physicians about any diagnosis or advice which they feel they do not understand.

Information to convey

1) Patients and doctors have mutual obligations and goals. When the patient does not indicate that something is unclear, the doctor is unlikely to offer a fuller explanation.
2) Many patients are reluctant to ask questions because they know doctors are busy, but patients have a right to a clear understanding of their problem and its treatment.

Rationale for choice of topic 2 (symptom descriptions)

The patient's ability to describe symptoms and the circumstances surrounding them can be a critical factor in accurate diagnosis. Many patients are unaware of its importance; one study showed that 65% of patients felt that their histories and symptom descriptions were the least important part of their visit to a doctor. Poor reporting of symptoms presumably accounts for many cases of misdiagnosis and inappropriate (and thus ineffective) treatment.

Behavioral goal 2

To motivate viewers to write a description of their symptoms (changes in the way they feel or in their ability to function) before visiting a physician.

Information to convey

1) Accurate description of symptoms aids the doctor in making a diagnosis and selecting appropriate treatment.
2) Writing a description of symptoms reduces the chance of forgetting or omitting something important during the stress of an office visit.
3) A written list can save time and thus make the visit more efficient for both the patient and the doctor.
4) During the course of an illness, the doctor may discontinue or change therapy inappropriately without clear information from the patient regarding changes in symptoms.

Rationale for choice of topic 3 (patients' rights)

Many people are unaware that they have a right to receive accurate and understandable information concerning their diagnosis and treatment, cost of services, possible involvement in medical experimentation, and the probable consequences of alternative treatments for a given health problem. Some medical authorities believe that improvements in the quality of care and increased patient cooperation in treatment will result from greater public understanding and use of patients' rights.

Behavioral goal 3

To motivate patients to seek information they may desire about such matters as diagnosis, treatment, institutional procedures, and cost of services.

Information to convey

1) The American Hospital Association's "Patient's Bill of Rights" lists 12 obligations of the hospital with regard to its patients. Among these are the patient's rights to be treated with respect and consideration; to be told about the nature of his problem, its treatment, and the chances for recovery; to be informed about the risks of any treatment; to refuse treatment and to be told what might happen as a result; to privacy during examinations and treatment; to refuse to be a part of a medical experiment; to examine his medical bill and have it explained.
2) If English is not a patient's first language, the hospital should provide an interpreter upon request.
3) Many hospitals have social workers or patient representatives who help patients exercise their rights.
4) Patients are entitled to ask questions and insist on clear answers.
5) Viewers can obtain a copy of "A Patient's Bill of Rights" from an organization whose name and address are given on the program.

Programming on doctor/patient communication and patients' rights

Season Program	Segment title	Running time	Format
A-4	"Film clip from 'Hospital'"	1:48	drama
	In this segment from the movie "Hospital", two doctors discuss a man who entered the hospital in a healthy condition but was almost killed by unnecessary surgery and damaging treatment.		
A-4	"Patient's Bill of Rights"	2:46	lecture/referral
	Consumer advocate Bess Myerson reads and explains seven items from the American Hospital Association's "Bill of Rights" and introduces a referral source where viewers can obtain their own copy.		
A-5	"Doctor/patient vox pop"	1:02	vox pop
	People give their impressions of what they believe doctors think of them.		
A-5	"Talk to Me"	1:52	song
	Charley Pride does a song about communication. Sample lyric: "Talk to me . . . you know that I depend on you . . . so won't you take the time . . . and maybe we can talk it through."		
A-5	"Patients Rap"	3:08	documentary
	Patients talk about visits to their doctors, noting times when they wanted more information.		
A-11	"Symptom Writers"	2:13	comedy sketch
	A sketch done in the style of a self-improvement TV commercial. A course in symptom writing is offered to enable a person to write down symptoms so that they won't be forgotten during a visit to the doctor.		
A-11	"Doctor/patient vox pop"	1:56	vox pop
	Several people talk about their fears concerning visits to a doctor.		
A-11	"Dr. Mumford"	1:51	interview
	Dr. Emily Mumford discusses some barriers to doctor/patient communication and notes the value of writing a description of symptoms before visiting a doctor.		

B-7 "If I Tell Him Where It Hurts,
Will He Listen?"
(program title)

Dick Cavett as host 6:34 host comments

Cavett introduces program and provides comments which bridge the various segments.

"Language Breakdown" 2:58 comedy sketch

A patient and his doctor have a conversation in which each uses terminology the other doesn't understand.

"Candid Comments" 1:28 vox pop

People on the street try unsuccessfully to define some medical terms.

"Dr. Belsky at work" 3:18 documentary

Dr. Marvin Belsky, shown conversing with patients, demonstrates how communication can be improved and notes that "demystification of the doctor is a job for both doctor and patient".

"Fear of Machinery" 1:17 comedy sketch

Dramatization of situation in which doctor fails to understand or allay patient's anxiety about taking a diagnostic test.

"Blood Pressure Demonstration" :35 demonstration

Cavett is shown with sphygmomanometer and notes that most doctors or technicians will answer questions if patients ask.

"Mrs. Pincus" 2:11 interview

Mrs. Pincus, a patient representative in a hospital, discusses the nature of misunderstandings between doctors and patients.

"Amelia and the Doctor" 1:40 comedy sketch

Woman patient who imagines various ailments insists that the doctor has not discovered her real problem.

"Patients' and Doctors' Comments" 4:19 vox pop

Several people describe unsatisfying encounters they have had with doctors. Doctors comment on problems with terminology, medical training, and frustrating patients.

"Jenny"	2:09	drama

Dramatization of encounter between young woman and her doctor. She comes to the office with accurate and complete description of symptoms; the doctor is both honest and reassuring.

Other program elements	2:09	bridges, credits, referral, etc.

Findings. For whatever reasons, viewership of program B-7, which was devoted to the topic of doctor-patient communication/relationships, was the lowest of all the Season B programs covered in the test interval for both the NORC and RAC studies. The reduced base of viewers made it virtually impossible to establish statistically significant viewing effects for that program. In the NORC study, no effects were found for the following items:

1) NORC Posttest, Q4-p: When a doctor orders treatment, a patient has the right to say she does not want it. (agree) The higher viewership registered for Season A programming did provide some weak evidence of an effect on this item from Season A, where this topic was dealt with in program A-4.

2) NORC Posttest, Q4-n: It's not good to ask a doctor a lot of questions about your illness--he'll tell you what you need to know. (disagree)

3) NORC Posttest, Q14: It's not important to give your doctor a complete description of your symptoms--he'll find uut what's wrong with you when he examines you. (disagree)

4) NORC Posttest, Q17: The doctor should help the patient describe his symptoms. (disagree)

5) NORC Posttest, Q5: When you are getting ready to speak to a doctor about yourself or someone else in the family,

do you . . . (write a list of the complaints and symptoms so you won't forget).

6) NORC Baseline Q42-a; NORC Posttest Q6-a: Some people say that doctors usually don't tell you enough about your condition; they don't explain just what the trouble is. . . . When that happens to you, how often do you ask the doctor to tell you more about the condition? (all the time)

The one suggestive finding from the NORC study in the doctor-patient relationships topic area is displayed in Table 49, and the one significant difference there is suspect because some of the nonviewers exhibited the desired opinion as much as the high viewers did.

Several items originally intended by RAC to assess attitudinal effects of program B-7 were not treated directly in that program. The opinion statements used, with response percentages based on all respondents (N = 3,705), are presented below for descriptive purposes only. RAC Posttest Q16: Which is closer to the way you feel . . .

a. (1) A doctor should tell you what his services cost even if you don't ask. (48%)
   (2) It is up to the patient to ask the doctor what the cost is going to be. (45%)

b. (1) A doctor should tell you what is wrong even if you don't want to know. (48%)
   (2) A doctor should withhold bad news if he feels you are not ready for it. (46%)

c. (1) A patient should follow his doctor's instructions even if he doesn't agree. (85%)
   (2) A patient should follow his doctor's instructions only if he thinks they will do him some good. (10%)

Table 49. DOCTOR/PATIENT RELATIONSHIPS: OPINION EFFECTS (NORC)

NORC Wave 3, Q4-g: When a doctor orders treatment, a patient has the right to say she does not want it. (agree)

Season A	TREATMENT GROUP A Induced to view & be interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No inducements
	High Viewer (N=66)	Low Viewer (N=97)	Nonviewer (N=46)	Nonviewer (N=85)
% agree:	91	79*	91	82

*Significantly different from High Viewing group, p <.05, 1-tail

Table 50. DOCTOR/PATIENT RELATIONSHIPS: SUGGESTIVE SEASON A BEHAVIORAL EFFECTS (RAC)

RAC Interim 3, Q1-e: (In the past 2 months have you..) written down your symptoms before visiting a doctor? (yes)

	Viewed show A-11	Viewed A-9 or A-10, but not A-11	Nonviewer
Pretested Rs:			
N:	(41)	(77)	(285)
% yes:	21	6*	7
Panel Control Rs:			
N:	(35)	(66)	(246)
% yes:	19	13	10

* Significantly different from viewers of Program A-11, p < .05, 2-tail

Table 51. DOCTOR/PATIENT RELATIONSHIPS: SUGGESTIVE SEASON B BEHAVIORAL EFFECTS (RAC)

RAC Posttest Q 6-b: (Since the last week of March, have you) Written down your symptoms before visiting a doctor? (yes)

Based on all respondents

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-7:	(95)	17	(180)	24	(106)	24
B. View Other Shows:	(442)	19	(781)	17	(422)	20
C. Nonviewers:	(729)	9	(1478)	12	(538)	13
Estimate of Effect=A-B:		-2%		7%		4%

RAC Posttest Q 6-b: (Same as above, only based on respondents 35-54 years of age.)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 452)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 836)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 379)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-7:	(30)	24	(49)	23	(25)	24
B. View Other Shows:	(160)	19	(273)	14	(152)	16
C. Nonviewers:	(262)	7	(514)	10	(202)	7
Estimate of Effect=A-B:		5%		9%		8%

Table 52. DOCTOR/PATIENT COMMUNICATION: PROGRAM B-7 SUGGESTIVE BEHAVIORAL EFFECTS (RAC)

RAC Posttest Q 6-f: (In the past 2 months have you) Asked the doctor to explain when he told you something you didn't understand? (Yes)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % Yes	Base N	B-Post % Yes	Base N	B-Post % Yes
A. View Show B-7:	(95)	49	(180)	60	(106)	52
B. View Other Shows:	(442)	47	(781)	44	(422)	46
C. Nonviewers:	(729)	35	(1478)	34	(538)	42
Estimate of Effect=A-B:		2%		16%***		6%

RAC Posttest Q6-f: (All respondents, as above, but subdivided by sex.)

POST-ONLY ANALYSES Male/Female	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 331/934)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 613/1824)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 292/774)	
	Base N	B-Post % Yes	Base N	B-Post % Yes	Base N	B-Post % Yes
A. View Show B-7:	(23/72)	53/45	(38/142)	54/62	(26/80)	54/51
B. View Other Shows:	(108/334)	39/51	(182/599)	33/49	(105/317)	37/50
C. Nonviewers:	(200/528)	25/42	(393/1083)	27/38	(161/377)	37/46
Estimate of Effect=A-B:		14/-6%		21/13%**		17/1%

** $p < .01$, 2-tail
*** $p < .001$, 2-tail

d. A doctor should call in a second opinion if his patient requests one.

(1) strongly agree (70%)

(2) agree (26%)

Behavioral goals on the topic of doctor-patient relationships included getting people to ask the doctor for explanations when they didn't understand him, and getting people to write down their symptoms before seeing the doctor. The NORC study found no impact on either of these behaviors, but the RAC study found suggestive evidence, falling short of statistical significance, on both of them. All three RAC Interim Measures asked an identical question as to whether the respondent had, in the preceding two months, asked a doctor to explain something he/she didn't understand. Viewers consistently reported higher levels of doing this, by about 10% but this was all attributable to self-selection factors rather than impact of Season A programming. Analysis by three levels of viewing Season B, program B-7 suggests behavioral impact attributable to program B-7, especially among men, but falling short of statistical significance. Two suggestive effects were detected on the goal of getting people to write down their symptoms before seeing the doctor; they are displayed in Tables 50 and 51. Program A-11 had a statistically significant effect among the pretested respondents, but not among the unpretested panel control respondents, although that effect also was in the "right" direction. The overall effect, therefore, must be considered suggestive only.

Conclusions. Season A programming in the area of doctor-patient relationships resulted in equivocal evidence of two effects: (1) the opinion that a patient has the right to refuse treatment, and (2) the behavior of writing down symptoms before visiting a doctor. Program 7 in Season B resulted in two suggestive, but not statistically significant, behavioral effects: (1) asking the doctor to explain when the patient doesn't understand (greater impact among men than woman on this item); and (2) writing down symptoms before visiting a doctor (greatest impact, still not statistically significant, was among respondents between 35 and 54 years of age).

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of doctor/patient communication:

"I work as a medical assistant in a doctor's office and have become more conscious of the fact that patients don't understand medical terms and try to answer these questions more adequately."

"I learned how to write down what I want to ask my doctor, and to ask the doctor if you do not understand."

"I sincerely believe that by having faith in your doctor he can do more for you, especially when he knows you as a person."

"I'm not as bashful. I talk more freely to the doctor."

"A patient bill of rights; I sent for it."

"By seeing these programs I learned to relax and lose fear when I talk to my doctor. I have always had a fear of seeing a doctor."

"I learned more of how to approach my doctor when I am dissatisfied with his diagnosis or procedure -- I learned to ask questions."

"I learned that the use of medical terms by doctors is quite common and it is not just my doctor and I shouldn't feel awkward or "dumb" to ask for an explanation in layman's terms."

"I learned that I can painlessly assert myself more in the doctor-patient relationship without feeling intimidated. I have that right."

"Everybody has the same communication problems with doctors as I do. But now I'm better about stating what I have on my mind and getting an understandable answer."

"I realize that doctors are interested in their patients and now I write down my questions before a Doctor appointment."

Prenatal Care

Rationale for choice of topic

Adequate prenatal care is a major factor in the prevention of maternal and infant mortality and morbidity. An estimated one million children are born each year to mothers who lack medical care during pregnancy; it has been reported that as many as 40% of the women delivered in large metropolitan hospitals have received no previous prenatal care. The prevalence of toxemia is highest among lower-income women from minority groups, and one result is that the maternal mortality rate for blacks is almost four times higher than the rate for whites. The value of early prenatal care is that potential complications can be detected and brought under control.

Behavioral goals

To motivate women to seek medical advice as soon as they suspect they are pregnant, and to continue prenatal checkups throughout their pregnancy.

Information to convey

1) Reasons for seeking early prenatal care: to confirm pregnancy; to obtain an accurate estimate of delivery date; to identify any conditions which could cause complications during pregnancy; to obtain information about diet, exercise, personal hygiene, handling of minor discomforts, physical and psychological changes to expect during pregnancy, and symptoms which should be reported to the clinic or doctor.
2) Prenatal care should be obtained early and continued throughout pregnancy even if a woman has had children previously.

3) Where viewers can obtain additional information about arranging a prenatal examination.

Programming on prenatal care

Season program	Segment title	Running time	Format
A-1	"You're Changing My Life"	2:55	song
	Helen Reddy does a song expressing the feelings of a mother-to-be.		
A-1	"Pregnant Dreams"	1:56	film montage
	Scenes of several pregnant women who discuss their experiences, what they are doing for themselves, and their aspirations for their children.		
A-1	"Unborn Baby"	4:00	comedy monologue
	Bill Cosby portrays an unborn baby giving advice and requests to the woman who is carrying him. Points are made regarding a baby's need for calcium and iron, the importance of regular prenatal checkups, and a woman's care of her own health during pregnancy.		
A-1	"Birth Announcements"	1:06	film montage
	Narration accompanying a series of photographs of mothers with their babies emphasizes the importance of prenatal care.		
A-1	"Prenatal Referral"	1:06	lecture/referral
	Helen Reddy tells viewers why prenatal care should start as soon as a woman suspects she is pregnant and continue throughout pregnancy--even if she has other children. "Referral" for additional information is introduced at end of segment.		
A-6	"Expectant Mother"	1:16	"commercial"
	A woman standing beside a crib with her baby tells viewers about the problems she had during pregnancy. She advises women who are pregnant to see a doctor and explains why this is important.		
A-6	"Expectant Father"	5:39	comedy monologue
	Bill Cosby describes the trials and tribulations of a man whose wife is pregnant. At the end he advises men to make sure that their pregnant wives make regular visits to the doctor and gives reasons for doing so.		

A-6 "I'm Alive" 3:05 song

Helen Reddy sings about the feeling of being alive ("I can hear the laughter . . . feel the sun above . . . I can reach out and touch you . . . I can love . . .").

A-6 "Prenatal Referral" :17 referral

Bill Cosby introduces a "referral" indicating where viewers can get information about regular prenatal care.

A-9 "Good Night, Nourse" 4:56 comedy sketch

Arte Johnson portrays a Scandinavian, who speaks no English, telling (through an interpreter) a traditional Norse story about childbirth, the point of which is to get prenatal care.

A-9 "Frontier Nursing" 8:01 documentary

A traveling nurse in the mountains of Kentucky is shown advising women about prenatal care. The segment includes information about risk conditions during pregnancy.

A-9 "Prenatal Referral" :31 referral

A source is given from which viewers can obtain additional information about prenatal care.

Findings. In general, there was no informational/attitudinal impact in this area, primarily because ceiling effects were encountered. The various goal areas measured, and descriptive data based on all respondents (i.e., undifferentiated as to viewing pattern) are summarized below:

1) The need for prenatal examinations. (agree-disagree items)

   a. RAC Interim 1, Q10-b: A woman who has already had one healthy child only needs to see the doctor a couple of times when she becomes pregnant again. (95% disagreed; N = 518)

   b. NORC Wave 2, Q6-a, and NORC Wave 3, Q4-k: A woman who has already had one healthy child doesn't need much prenatal care if she becomes pregnant again. (Wave 2: 95% disagreed, N = 136; Wave 3: 93% disagreed, N = 308)

   c. RAC Interim 1, Q10-c, and RAC Interim 2, Q6-a: When a woman becomes pregnant, she should . . . see a doctor early in her pregnancy. (Interim 1: 99% said yes, N = 518; Interim 2: 98% said yes, N = 466)

Table 53. PRENATAL CARE: SUGGESTIVE BEHAVIORAL EFFECTS (RAC)

RAC Interim 1, 2, and 3, Q1-1: (In the past two months . .) Have you encouraged someone who is pregnant to go to the doctor early in her pregnancy?

Interim 1

	View Prg. A-1	View A2-A4 but not A1	A1-A4 nonviewer
Base N:	(83)	(43)	(392)
% yes:	17	7	13

Interim 2

	View Program A-6	View A5-A8 but not A6	A5 - A8 nonviewer
Base N:	(49)	(74)	(328)
% yes:	23	12	11

Interim 3
Pretested Respondents

	View Program A-9	View A10-11 but not A-9	A9-A11 nonviewer
Base N:	(91)	(27)	(285)
% yes:	19	24	11

Interim 3
Panel Control

	View Program A-9	View A10-11 but not A-9	A9-A11 nonviewer
Base N:	(68)	(33)	(246)
% yes:	18	8	12

d. RAC Interim 2, Q6-b: If she feels all right, a pregnant woman only needs to see a doctor once or twice before she has her baby. (93% disagreed, N = 466)

2) Dietary aspects of prenatal care.

a. RAC Interim 1, Q10-c and RAC Interim 2, Q6-a: When a woman becomes pregnant, she should . . . watch her diet more carefully. (Interim 1: 68% said yes, N = 518; Interim 2: 79% said yes, N = 466)

b. NORC Wave 3, Q4-p: A pregnant woman should cut down on the amount of salt in the food she eats. (94% agreed, N = 308). RAC Interim 3, Q9: A pregnant woman should limit the amount of salt in the food she eats. (82% of the pretested respondents agreed, N = 411; 81% of the unpretested panel control respondents agreed, N = 353).

The only behavior measured in this topic area was the urging of someone else who is pregnant to see a doctor early in the pregnancy. Results here are highly suggestive of behavioral impact, but fall short of statistical significance, as displayed in Table 53.

Conclusions. In the topic area of prenatal care, ceiling effects on most of the information and opinion items made it impossible to register impact on viewers concerning the need for prenatal examinations or dietary aspects of prenatal care. Behavioral data from Season A were highly suggestive that viewing increased the incidence of encouraging pregnant women to see a doctor early in the pregnancy, but the data fell short of statistical significance.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of prenatal care:

"I try harder to take better care of my health since I'm expecting another child. I am eating a better balanced diet than when I had my last baby."

"I learned how you're supposed to carry yourself through your pregnancy."

"I learned about diets and exercise during pregnancy."

Exercise

Rationale for choice of topic

Heart specialists generally agree that endurance exercises such as jogging, swimming, and cycling are the most beneficial for the heart. However, 45% of adult Americans (about 49,000,000 men and women) do not engage in physical activity for the purpose of exercise. Overstressing the body by engaging in strenuous exercise after a pattern of sedentary activity can be damaging. Moderate exercise on a regular basis can produce significant health benefits.

Behavioral goals

1) To motivate viewers to check with a doctor or other health professional before beginning any strenuous exercise regimen.
2) To motivate viewers to engage in some moderate physical activity daily.

Information to convey

1) Since the type and amount of strenuous exercise should be tailored to the individual's physical condition, a doctor or other qualified health professional should be consulted before undertaking any new strenuous exercise.
2) Increases in the level of physical activity should be gradual.
3) Strenuous exercise benefits the heart; active people have fewer heart attacks than inactive people.
4) Health benefits can be achieved through moderate levels of activity: regular moderate exercise improves muscle strength and endurance, heart and lung functioning, and posture.

5) Walking and bicycling are recommended forms of moderate exercise and often can be included in a normal daily routine.

Programming on exercise

Season Program	Segment title	Running Time	Format
A-2	"You're Getting Fat"	3:04	song
	Pearl Bailey does a humorous song about the signs of getting fat.		
A-2	"The Exerciser"	6:30	parody
	In this take-off on the film "The Exorcist", the priest is replaced by a physical fitness expert who "saves" a gluttonous young man who does not exercise. The segment emphasizes the need for balance between caloric intake and caloric expenditure.		
A-2	"Muffin"	1:10	graphic/animation
	A series of graphics accompanied by narration describing various kinds and amounts of exercise which would consume the 100 calories contained in a muffin.		
A-2	"Walking Shoes"	2:25	song
	Anne Murray does a song which deals abstractly with the relationship between walking and feeling good.		
A-3	Mac's Place segments	14:03	situation comedy
	Segments throughout the program deal with the efforts of Hank, an overweight middle-aged man, to "get in shape" by starting a vigorous exercise program. Points are made about checking with a doctor first, starting gradually, and reducing caloric intake.		
A-3	"Walking Really Moves You"	2:07	song
	The Mac's Place cast members move along with a marching band in this song stressing the values of walking as a form of exercise.		
A-4	"Fred Goes Jogging"	1:12	"commercial"
	Middle-aged Fred goes jogging to lose weight, but overdoes it and ends up in the hospital.		

A-7 "Resolutions" 3:25 vox pop

Several people at a New Year's Eve party make resolutions about getting in shape during the coming year.

Findings. The data identify exercise as an area where fundamental information and advocated attitudes were either widely known and accepted before, during, and after the series, or were so prone to social acceptability pressures that the response given was the response people felt was desirable or expected. On NORC's baseline measure and Wave 2, virtually all respondents considered exercise either very important or somewhat important (Qs 34 and 9). Over three-fourths of the NORC respondents agreed before, during, and after the series that people who do regular exercise have fewer heart attacks; there was weak evidence of a viewing effect in Wave 2 and suggestive evidence of a viewing effect in Wave 4 (baseline Q35; Wave 2, Q6-g; Wave 4, Q4-f). Among 518 RAC Interim 1 respondents, 86% disagreed with the proposition that walking is not much good as physical exercise (Q5-b). Of the 134 NORC Wave 2 respondents, 67% agreed that you will gain weight unless you exercise off all the calories you eat. (Q6-e). Viewing or not viewing the series had no demonstrable effect on this body of information and opinion.

At one level, exercise programs should be prescribed individually on the basis of professional assessment of several interrelated factors such as age, weight, diet, goals, and physical condition. In the area of more general needs (such as approaching exercise seriously and systematically) and behaviors that can be advocated almost universally (such as walking), there tends to be less precision in framing questions or answers in multi-topic survey methodology. The more general the question, the less assurance one can have that the same kind or degree of activity is being commonly referred to. This limits the precision of interpreting such self-reports as these: over 80% of the RAC baseline respondents said they try to get some exercise every day

Table 54. DESCRIPTIVE BEHAVIORAL DATA ON EXERCISE (GALLUP, RAC, NORC)

Gallup item: In the last two months, have you increased the amount of regular exercise that you do?

Gallup Survey #	1	2	3	3	4	4
Field date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for last two months only:	X	X	X		X	
Q asked first for 6, then 2 mos.:				X		X
Base N:	(1517)	(1544)	(785)	(814)	(799)	(826)
% yes:	27	25	33 - - - -	-21	36- - - -	23

RAC item: (In the last two months . .) Have you increased the amount of exercise you do?

RAC Interim #	1	2	3	3 (Panel Control)
Field date:	12/74	1/75	3/75	3/75
Base N:	(518)	(466)	(411)	(353)
% yes:	38	46	44	52

NORC item: Since we last talked, have you started on a regular program of exercise for yourself?

NORC Wave #	2	3	4
Field date:	12/74	2/75	5-6/75
Base N:	(136)	(308)	(467)
% yes:	37	30	47

(Q5-b); about half of the NORC baseline respondents felt they were getting enough exercise already (Q34). In the behavioral areas of initiating or increasing personal exercise programs, the limits on precision of questionnaire items may or may not have been a significant factor in the lack of statistically significant behavioral consequences of the series. In view of the fact that no consistent relationships between viewing patterns and behavioral reports could be made, all behavioral data are presented as descriptive only, and are undifferentiated as to viewing patterns (Table 54).

Conclusions. In the topic area of exercise, the series had no significant impact on knowledge, attitudes or behaviors as measured. The presence of ceiling effects, in addition to weaknesses in the questionnaire items, made any demonstration of impact unlikely.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of exercise:

"I now walk up and down stairs more -- no elevators!"

"I learned about the importance of checking with your doctor before getting involved in an exercise. I use my head."

"I learned how to take care of myself more. How to take exercise and try to help someone else do the same thing."

"I've started exercising -- something I normally don't do."

"I learned how much exercise a person has to do to burn up calories."

"I looked at myself in the mirror and found myself ugly with bulges. Now I rush to do my housework to have more time for exercise."

"I've been a real nut on diets anyway. But now I'm starting to exercise more."

"I plan to start exercising. We've got a pool now so I'll probably be doing a lot of swimming."

"I learned about the exercise a heart attack victim needs."

"I now do exercises two or three times a week."

"I'm more conscious of what kind of exercise is helpful and not helpful for health."

Vision

Rationale for choice of topic 1 (preschool screening)

One in every 20 children aged three to six has a vision problem. Early discovery and treatment is a critical factor in successful correction for amblyopia ("lazy eye"). One in every four school children, or about 13,000,000, are in need of some form of eye care. Vision problems frequently interfere with school achievement and social adjustment.

Behavioral goal 1

To motivate parents or others responsible for child care to take their preschool children (age 4) for a vision screening.

Information to convey

1) Most vision problems are treatable (and/or curable) if they are detected before school age.
2) Children can have vision problems which may not be noticeable to their parents (i.e., they may have no apparent symptoms).
3) Uncorrected vision problems can have serious consequences for the child--e.g., difficulty in learning to read, poor school performance, emotional problems.
4) A child's vision can be checked before the child learns to read.
5) Vision screening is painless, takes only a few minutes, can be enjoyable for the child, and is not expensive.
6) Where viewers can find out how to arrange a screening.

Rationale for choice of topic 2 (glaucoma screening)

Glaucoma is the second-ranked cause of blindness in the U.S. An estimated 1,750,000 people over 35 years of age have glaucoma, but more than 50%

are unaware of it; symptoms often are absent until the disease is at an advanced stage. Early detection, followed by control through medication, can arrest the disease.

Behavioral goal 2

To motivate people over age 35 to have their eyes checked for glaucoma.

Information to convey

1) Glaucoma can cause blindness, and the sight it destroys cannot be restored.
2) Symptoms often are absent until the disease is advanced, so one can have glaucoma without knowing it.
3) The tonometer test for glaucoma is quick and painless.
4) In cases found early enough, glaucoma can be controlled through the use of prescribed eye drops.
5) People over 35 should have a tonometry test every year, and more often if they have a family history of diabetes or glaucoma.

Programming on vision

Season Program	Segment title	Running Time	Format
A-2	"The First Time"	3:43	illustrated song/ demonstration
	Film of children in various activities illustrates the lyrics of a song by Anne Murray (". . . the first time I saw the leaves on a tree, a beautiful world opened to me . . ."). Middle part of segment shows children taking vision and hearing tests, and gives reasons why early tests are important. Segment closes with reprise of song and film.		
A-11	"Bet You Didn't Know"	1:02	"commercial"
	A woman offers to make a bet with viewers that they can't tell whether their preschool children have a vision problem. Makes the point that some problems can be detected only through an eye examination.		

B-4 "Two Eyes for Keeps"
(program title)

Dick Cavett as host 5:19 host comments

Speaking in Metropolitan Museum of Art, Cavett discusses importance of vision and introduces topic of screening test for glaucoma and amblyopia.

"Steve Shaw" 8:42 documentary

The story of how five-year-old Steve Shaw's amblyopia was discovered and successfully treated.

"Dora Bruton" 9:38 documentary

The detection and treatment of glaucoma is shown through the story of Mrs. Dora Bruton.

"Would You Like to See the World with Me?" 2:15 song

The lyrics of this song by Betty Buckley deal with the pleasures of being able to see well.

Other program elements 2:51 bridges, credits, referral, etc.

Findings on Adults' Vision. On the following four items, no effects could be attributed to the Season B program on vision (B-4):

1) NORC Wave 4, Q9: How often do you think people over 35 should have their eyes checked for glaucoma? (every year) (The RAC study did have a suggestive but not significant effect here; see Table 56.)

2) NORC Wave 4, Q1-d: Since March first, have you had an eye examination? (yes) (Note that the RAC study did have a significant effect here.)

3) RAC Posttest, Q12-c: If glaucoma is diagnosed before a person becomes blind. . . (the condition can be arrested).

4) RAC Posttest, Q12-d: What is the most common form of treatment for glaucoma? (medicated eyedrops)

Significant or suggestive information effects are displayed in Tables 55-57. A significant behavioral effect is shown in Table 58, and Gallup trend data are shown in Table 59.

Again, there was an apparent inflation of self-reported behaviors (approximately 10 percentage points) that was removed by first asking respondents about health behaviors for the past six months, then asking about behaviors during the past two months. Similar behavioral reports among nonviewers in the NORC study ranged between 16% and 26%, and between 15% and 21% in the RAC nonviewers, possibly indicating some inflation there as well. As discussed in the earlier section on breast cancer, however, there is no reason to assume that the relative effects among treatment or viewer groups would be affected by this.

Conclusions. FEELING GOOD program B-4 on vision increased the proportions reporting that one can have glaucoma without knowing it; that diabetes in the family increases one's chances of having glaucoma; and, in one of two studies, it increased the proportions reporting recent eye examinations by a doctor. This behavioral impact was most apparent among adults over 54 years of age.

Findings on Children's Vision. Among parents of children under six years of age, 30% of the NORC respondents and 36% of the RAC respondents reported that their oldest preschool child had received a vision test prior to the beginning of the FEELING GOOD series. This still leaves a substantial proportion in the target audience as prospects for this advocated behavior, but no impact was discernible on the following items:

1) The vision material presented in program A-2 had no impact on reported incidence of taking a child for a vision test in the last two months (RAC Interim 1, Q1-q).

Table 55. VISION: PROGRAM B-4 INFORMATIONAL EFFECTS (RAC POSTTEST Q 12-b)

RAC Posttest Q 12-b: A person can have glaucoma and not know it. (Mostly true)

POST ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(92)	79	(155)	76	(71)	77
B. View Other Shows:	(445)	67	(806)	72	(457)	67
C. Nonviewers:	(729)	68	(1478)	66	(538)	68
Estimate of Effect=A-B:		12%*		4%		10%

PRE-POST ANALYSES	INTRA-GROUP COMPARISONS FOR SEASON B PRE to POST EFFECTS (group 2 above, pre to post)				
	B-Pre:	+	+	-	-
	B-Post:	+	-	+	-
	Base N	%	%	%	%
A. View Show B-4:	(155)	57	10	19	14
B. View Other Shows:	(804)	60	10	12	18
C. Nonviewers:	(1475)	53	12	12	23

Definition of Effect Estimate: Subtract % "backsliders" (Pre+, Post -) from % "converts" (Pre-, Post+) for viewing levels A, B, and C. Then, Effect = (A-C)-(B-C) = (A-B)

Estimate of Effect: (pre to post gain) 7%*

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*p < .05, 2-tail

Table 56. VISION: PROGRAM B-4 INFORMATIONAL EFFECTS (RAC POSTTEST Q 12-a)

RAC Posttest Q 12-a: How often should people over 35 have their eyes checked for glaucoma? (every year)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N=1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(92)	60	(155)	53	(71)	53
B. View Other Shows:	(445)	50	(806)	49	(457)	47
C. Nonviewers:	(729)	48	(1478)	47	(538)	48
Estimate of Effect = A-B:		10%		4%		6%

PRE-POST ANALYSES

INTRA GROUP COMPARISONS FOR SEASON B PRE TO POST EFFECTS
(group 2 above, pre to post)

		B-Pre: +	+	-	-
		B-Post: +	-	+	-
	Base N	%	%	%	%
A. View Show B-4:	(155)	38	14	14	33
B. View Other Shows:	(804)	38	21	11	30
C. Nonviewers:	(1475)	35	23	12	30

Definition of Effect Estimate: Subtract % "backsliders" (Pre+, Post -) from %"converts" (Pre-, Post +) for viewing levels A, B, and C. Then, Effect=(A-C)-(B-C)= A-B.

Estimate of Effect: (pre to post gain) 10%*

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* p < .05, 2-tail

Table 57. VISION: PROGRAM B-4 INFORMATIONAL EFFECTS (NORC)

NORC Wave 4, Item 13:

Item: A person who has diabetes in his family runs a greater risk of having glaucoma. (Agree)

	TREATMENT GROUP A Induced to View and be interviewed		TREATMENT GROUP B Induced to be interviewed	TREATMENT GROUP C No inducement
	Viewer	Non-viewer	Non-viewer	Non-viewer
Show B-4:	N=(50)	N = (187)	N = (103)	N = (82)
% agree:	63	53	39**	30

** Significantly different from viewer group, $p < .01$, 1-tail

Table 58. VISION: PROGRAM B-4 BEHAVIORAL EFFECTS (RAC)

RAC Posttest Q 6-c: Since the last week of March, have you had your own eyesight checked? (Yes)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-post % correct	Base N	B-Post % correct
A. View Show B-4:	(92)	32	(155)	32	(71)	27
B. View Other Shows:	(445)	18	(806)	21	(457)	20
C. Nonviewers:	(729)	16	(1478)	15	(538)	19
Estimate of Effect = A-B:		14%*		11%*		17%*

*p < .05, 2-tail

Table 59. ADULT VISION: BEHAVIORAL TREND DATA (GALLUP)

In the past two months, have you had your eyes examined by a doctor?

Gallup Survey #	3	3	4	4
Field data:	4/75	4/75	5-6/75	5-6/75
Q asked only for past two months:	X		X	
Q asked first for 6 then 2 months:		X		X
Base N (adults):	(785)	(814)	(799)	(826)
% yes:	22 - - -	10	24 - - -	12

2) Viewers of 4 or more shows in the series (Season A and/or B) were only slightly more likely than nonviewers to report attempts to get information on testing children's vision or hearing (RAC Posttest, Q34-a).

3) The NORC study found no series impact on the incidence of taking the oldest preschool child for a vision check (NORC Baseline, Q2-C-(1); Wave 3, Q10-D-(1); Wave 4, Q1-e).

4) The RAC study found no impact on the general status of whether or not the oldest preschool child has had a vision test (RAC Posttest, Q34-b), but did find a suggestive (not statistically significant) effect on reports of taking a preschool child for a vision check.

Program B-4 contained the information that the optimum time to examine a child's eyes was before he or she started to read or go to school. Data on learning of this information was suggestive but not statistically significant in the RAC study (see Table 60), while there was weak statistical evidence of a learning effect in the NORC study.

Tables 61-63 cover several informational items from the RAC study. All items displayed have a statistically significant learning effect in one or more subgroups, so that data are interpreted here only as being suggestive, not statistically significant. The variations in subgroup effects are not consistent from item to item, and so must be dealt with individually.

Table 61 indicates that across all respondents, the incidence of having heard of amblyopia was higher among viewers of program B-4, which dealt with that topic. However, the difference was striking only among those receiving the Season B pretest. Cutting down to the more precise target audience of respondents with children under six reduced but did not eliminate the differences among the three respondent groups that presumably differed only in the type or number of pretests administered. These substantial variations from group to group make it impossible to conclude that a general and significant learning on this item had occurred as a result of viewing the program.

Table 62: Post-only analyses indicated that learning (that amblyopia is the condition of underuse of one eye) had taken place in all but the panel control group, and especially in the group both pretested and posttested for Season B. Further probing within this one pretested group shows that viewers of program B-4 exhibited fewer learning regressions and more learning advances than viewers of other shows or nonviewers, but the generally advanced status of this group on this item made them non-comparable with the other two groups. Table 62 displays the same item for respondents having children under six; the gains indicated for the three respondent groups varied widely, again making it impossible to interpret the data as indicating a general learning effect.

Table 63: Again, the pattern of effects is in the desired direction but is not uniform in magnitude. When all respondents were analyzed, the panel control group learning effects were not statistically significant. When only parents of children under 6 were analyzed, the respondents getting both Season B pretests and posttests differed very little as a function of viewing program B-4. Respondents pretested for Season B were higher in their pretest scores, which were registered well before program B-4 was aired, than other respondents were in their posttest scores, within each viewing level. Such variations across respondent groups preclude a clear conclusion of program impact.

Table 60. CHILDREN'S VISION: SUGGESTIVE AND SIGNIFICANT INFORMATIONAL EFFECTS ON THE TIMING OF EYE EXAMINATIONS (RAC AND NORC)

RAC Posttest Q 11: When should a child's eyes first be checked?
(before the child learns to recognize the alphabet)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS		REPEATED MEASURE RESPONDENTS		PANEL CONTROL RESPONDENTS	
Based only on respondents with children under 6 in the household.	Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 323)		Season A Pretest Season B Pretest Season B Posttest (N = 592)		Season B Posttest (N = 248)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(30)	77	(26)	79	(16)	75
B. View Other Shows:	(110)	73	(201)	71	(116)	70
C. Nonviewers:	(183)	63	(365)	63	(116)	67
Estimate of Effect=A-B:		4%		8%		5%

Table 60. (Cont'd.) CHILDREN'S VISION: SUGGESTIVE AND SIGNIFICANT INFORMATIONAL EFFECTS ON THE TIMING OF EYE EXAMINATIONS (RAC AND NORC)

NORC Wave 4, Item 8:

> When do you think a child's eyes should first be checked?
> (Before the child is six years old)
> (Based on all respondents)

	TREATMENT GROUP A Induced to View and be interviewed		TREATMENT GROUP B Induced to be interviewed	TREATMENT GROUP C No inducement
Show B-4: Viewing Status:	Viewer (N = 50)	Nonviewer (N = 187)	Nonviewer (N = 103)	Nonviewer (N = 82)
% correct:	82	77	65*	66

*Significantly different from viewer group, $p < .05$, 1-tail

Table 61. CHILDREN'S VISION: SUGGESTIVE INFORMATIONAL EFFECTS (RAC POSTTEST Q 13-a)

RAC Posttest Q 13-a: Have you ever heard of amblyopia? (Yes)
(Based on all respondents)

POST-ONLY ANALYSES (Based on all Respondents)	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(92)	33	(155)	71	(71)	40
B. View Other Shows:	(445)	29	(806)	43	(457)	35
C. Nonviewers:	(729)	22	(1478)	40	(538)	24
Estimate of Effect = A-B:		4%		28%***		5%

RAC Posttest Q 13-a: Have you ever heard of amblyopia? (Yes)
(Based on respondents with children under 6 in the household)

POST ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 323)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 592)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 248)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A View Show B-4:	(30)	36	(26)	76	(16)	66
B. View Other Shows:	(110)	38	(201)	49	(116)	39
C Nonviewers:	(183)	26	(365)	47	(116)	31
Estimate of Effect = A-B:		-2%		27%**		27%*

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* $p < .05$, 2-tail
** $p < .01$, 2-tail
*** $p < .001$, 2-tail

Table 62. CHILDREN'S VISION: PROGRAM B-4 SUGGESTIVE INFORMATIONAL EFFECTS (RAC)

RAC Posttest Q 13-b: Amblyopia is the condition of... (under use of one eye)
(based on all respondents)

POST-ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(92)	32	(155)	47	(71)	29
B. View Other Shows:	(445)	22	(806)	34	(457)	27
C. Nonviewers:	(729)	20	(1478)	31	(538)	22
Estimate of Effect = A-B:		10%*		13%*		2%

*p <.05, 2-tail

PRE POST ANALYSES	INTRA GROUP COMPARISONS FOR SEASON B PRE to POST EFFECTS (group 2 above, pre to post)				
	B-Pre:	+	+	-	-
	B-Post:	+	-	+	-
	Base N	%	%	%	%
A. View Show B-4:	(155)	28	4	19	50
B. View Other Shows:	(804)	26	9	8	58
C. Nonviewers:	(1475)	24	8	7	61

Definition of Effect Estimate: Subtract % "backsliders" (Pre+, Post-) from % "converts" (Pre-, Post+) for viewing levels A, B, and C. Then, Effect = (A-C)-(B-C) = A-B.

Estimate of Effect: (pre to post gain) 16%*

* p < .05, 2-tail

Table 62. (Cont'd.) CHILDREN'S VISION: PROGRAM B-4 SUGGESTIVE INFORMATIONAL EFFECTS (RAC)

RAC Posttest Q 13-b: Amblyopia is the condition of ....(underuse of one eye)
(Based on respondents with children under 6 in the household)

POST ONLY ANALYSES	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 323)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 592)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 248)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(30)	47	(26)	61	(16)	41
B. View Other Shows:	(110)	31	(201)	41	(116)	35
C. Nonviewers:	(183)	24	(365)	43	(116)	28
Estimate of Effect = A-B:		16%		20%		6%

Table 63. CHILDREN'S VISION: PROGRAM B-4 SUGGESTIVE INFORMATIONAL EFFECTS (RAC)

RAC Posttest Q 13-c: Which of these statements is closer to the facts ...
(A child with amblyopia may see well with one eye and appear to have normal vision.)

POST-ONLY ANALYSES (Based on all respondents)	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(92)	36	(155)	47	(71)	34
B. View Other Shows:	(445)	23	(806)	38	(457)	29
C. Nonviewers:	(729)	20	(1478)	32	(538)	23
Estimate of Effect = A-B:		13%**		11%*		5%

** p < .01, 2-tail

* p < .05, 2-tail

PRE POST ANALYSES	INTRA GROUP COMPARISONS FOR SEASON B PRE to POST EFFECTS (group 2 above, pre to post)				
	B-Pre:	+	+	-	-
	B-Post:	+	-	+	-
	Base N	%	%	%	%
A. View Show B-4:	(155)	27	10	20	43
B. View Other Shows:	(804)	29	10	10	52
C. Nonviewers:	(1475)	24	10	9	57

Definition of Effect Estimate: Subtract % "backsliders" (Pre+, Post-) from % "converts" (Pre-, Post+) for viewing levels A, B, and C. Then, Effect = (A-C)-(B-C) = A-B.

Estimate of Effect: (pre to post gain) 10%*

* p < .05, 2-tail

Table 63. (Cont'd.) CHILDREN'S VISION: PROGRAM B-4 SUGGESTIVE INFORMATIONAL EFFECTS (RAC)

RAC Posttest Q 13 -c: Which of these statements is closer to the facts...
(A child with amblyopia may see well with one eye and appear to have normal vision.)

POST ONLY ANALYSES (Based on Respondents who have children under 6 in the household)	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 323)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 592)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 248)	
	Base N	B-Post % correct	Base N	B-Post % correct	Base N	B-Post % correct
A. View Show B-4:	(30)	51	(26)	45	(16)	46
B. View Other Shows:	(110)	31	(201)	43	(116)	32
C. Nonviewers:	(183)	24	(365)	42	(116)	29
Estimate of Effect = A-B:		20%*		2%		14%

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* p < .05, 2-tail

Table 64. CHILDREN'S VISION: PROGRAM B-4 SUGGESTIVE BEHAVIORAL EFFECTS (RAC)

RAC Posttest Q 6-d: Since the last week in March, have you taken a preschool child for an eyesight or vision test? (Yes)

POST-ONLY ANALYSES (Based on all Respondents)	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 1266)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 2439)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 1066)	
	Base N	B-Post % yes	Base N	B-Post % yes	Base N	B-Post % yes
A. View Show B-4:	(92)	10	(155)	8	(71)	7
B. View Other Shows:	(445)	6	(806)	5	(457)	7
C. Nonviewers:	(729)	4	(1478)	4	(538)	5
Estimate of Effect = A-B:		4%		3%		0%

RAC Posttest Q 6-d: (Same as above)

POST ONLY ANALYSES (Based on respondents with children under 6)	REPEATED MEASURE RESPONDENTS Season A Pretest 1 Season A Interim Measure Season B Posttest (N = 323)		REPEATED MEASURE RESPONDENTS Season A Pretest Season B Pretest Season B Posttest (N = 592)		PANEL CONTROL RESPONDENTS Season B Posttest (N = 248)	
	Base N	B-Post % yes	Base N	B-Post % yes	Base N	B-Post % yes
A View Show B-4:	(30)	23	(26)	43	(16)	27
B. View Other Shows:	(110)	20	(201)	16	(116)	18
C Nonviewers:	(183)	14	(365)	15	(116)	16
Estimate of Effect = A-B:		3%		27%**		9%

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* p<.01, 2-tail

Table 65. CHILDREN'S VISION: BEHAVIORAL TREND DATA (GALLUP)

Item: In the past two months, have you had your children's eyes examined by a doctor? (yes)

Gallup Survey No.:	3	3	4	4
Field Date:	4/75	4/75	5-6/75	5-6/75
Q asked for 2 months only:	X		X	
Q asked first for 6 then for 2 months:		X		X
Base N:	(392)	(411)	(375)	(397)
% yes:	22 - - -	15	23 - - -	17

Conclusions. The series had no significant behavioral impact in the area of children's vision, either in the seeking of information or in taking preschoolers for a vision test. There were indications of informational effects about amblyopia, but these indications varied among methodologically-defined subgroups to the extent that they must be considered suggestive only. The NORC study indicated a learning effect (also suggested in the RAC study) for the information that children's eyes should be examined before the child starts to read or go to school.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of vision:

"We go to the eye doctor once a year and your program made us glad we do."

"I learned about the exact nature of amblyopia, how early it can and should be detected, how it is corrected and that it can be successfully corrected. If my child (over 6) had not had a screening, and she was very young, I would have taken her for one immediately."

"I visited my eye doctor in May and found a disorder in my vision that could be corrected. Very thankful."

"I urged my grandfather to see an opthamologist at which time it was discovered he had two cataracts, no sign of glaucoma, and a need for a prescription change in lenses of his glasses."

"I'm having the children's eyes checked before school so they won't have that thing that slows them up."

"I had my eyes checked for glaucoma. And I learned about the lazy eye."

"I learned about glaucoma. I had never heard of it. I'm more careful about my family's eyesight."

"I learned that a young child should have an eye examination early in life to see if he or she has amblyopia since it can't be detected by the parents, since the child sees well out of one eye."

"I learned about the little boy with one weak eye -- I'm going to have my little girl examined for this."

"We tested our son's vision ourselves to rule out the weakness. We had never heard of this."

"I learned to keep a close check on my little boy's eyes."

"My daughter had an eye exam for her 4 year old at my suggestion."

Dental Care

Rationale for choice of topic 1 (sugar consumption)

Children consume large quantities of sugar in the foods they eat as snacks between meals. Dental authorities generally agree that a reduction of sugar intake would benefit health in general and would be a particularly important step in the prevention of dental disease, which affects about 98% of the U.S. population.

Behavioral goal 1

To motivate parents or others responsible for child care to reduce sugar consumption (especially sweet snacks) by their children.

Information to convey

1) Sugar consumption promotes tooth decay and periodontal or gum disease.
2) Other foods (nuts, cheese, fruits, etc.) can be used for snacks in place of foods high in sugar.
3) Nutritious snacks are often cheaper than those high in sugar.

Rationale for choice of topic 2 (dental plaque)

Plaque is a film which forms continuously on teeth and leads to tooth decay and gum disease. Large numbers of people experience pain and loss of teeth because plaque is not removed regularly. Because plaque is invisible, many are unaware that their tooth cleaning practices are ineffective. A trial use of disclosing tablets, which reveal the presence of plaque, could lead to improved dental care habits and thus to maintenance of dental health. (In a recent national survey, only 24% of adults reported having heard about plaque, and only 20% had ever been shown how to make sure they were cleaning their teeth completely.)

Behavioral goal 2

To motivate viewers to make a trial use of disclosing tablets.

Information to convey

1) Disclosing tablets reveal the presence of plaque on the teeth.
2) Plaque is a colorless film of bacteria formed continuously on the teeth.
3) Plaque formation on the teeth leads to tooth decay and gum disease, and can lead to loss of teeth.
4) Plaque should be removed regularly (preferably daily).
5) Plaque can be removed effectively by appropriate toothbrushing and use of dental floss.
6) Disclosing tablets are inexpensive and can be obtained from a dentist or drugstore.
7) Loss of teeth as one grows older is not inevitable; properly cared for, teeth can last a lifetime.

Programming on dental care

Season, program	Segment title	Running time	Format
A-1	"Teeth in Glass"	:31	"commercial"
	Animation of teeth asking questions such as "Why go to a dentist? Why bother to brush after every meal? If your tooth has a cavity, pull it out." Teeth are shown to be a false set as voice-over narrator says "Be true to your teeth, or they'll be false to you."		
A-3	"Toothbrush Hall of Fame"	3:10	comedy sketch
	Bob & Ray conduct an interview in the Toothbrush Hall of Fame. Points are made about the value of daily brushing and use of dental floss to remove plaque.		
A-3	"Kids and Teeth"	3:38	demonstration

Dr. Mercado, a dentist, explains to a group of children how plaque forms on teeth. An effective method of brushing teeth is demonstrated.

A-3 "Disclosing Tablets" :56 "commercial"

A woman speaking directly to the viewer explains what plaque is and tells how to obtain free disclosing tablets from the American Dental Association.

A-5 "Teeth in Glass" :31 (same as in A-1 above)

A-6 "Don't Call Me Sugar" 2:12 song

Pearl Bailey sings to a live audience about how she hates to be called sugar because sugar is bad for the teeth.

A-6 "To Tell the Tooth" 6:26 parody

In this take-off on a TV game show, panelists try to guess which of three contestants is the one with all of his permanent teeth. The questions asked of the contestants, and their answers, clarify the differences between good and poor dental health habits.

A-6 "Semi-Cola" 1:08 "commercial"

This humorous segment shows what can happen to teeth when too much sugar-laden cola is consumed. Elements are a jingle and a visual of young cola consumers at the beach.

A-6 "Sweetsteaks" :43 "commercial"

A child is eating breakfast in a setting typical of TV commercials for cereals; suddenly the leprechaun printed on the cereal box comes to life and announces that the ingredient of the cereal is...sugar.

A-6 "Sugar Baby" 2:11 animation/graphic

Suggestions on how to save a child's teeth (avoiding sticky sweets and chewy candies, using a straw to drink soda pop, etc.). Elements are graphics accompanied by narration.

A-9 "Smiling Montage" 3:56 vox pop

Several people in "man on the street" comments about the importance of having healthy and attractive teeth. Segment serves to introduce the following segments about dental care.

A-9 "Tooth Fairy" 4:30 comedy monologue

Bill Cosby reminisces about the fact that losing a tooth as a child was a financially rewarding experience; at the end he contrasts this with losing teeth as an adult.

A-9 "I Like Your Smile" 1:47 song

John Davidson does a song which implies that an attractive smile is a definite asset.

A-9 "Teeth in Glass" :29 "commercial"

(same segment used program A-1)

A-11 "Count of Monte Cresto" 1:47 "commercial"

Good strokes for brushing teeth are demonstrated by the Count as he duels Baron Badmouth. Swordplay scenes are intercut with closeups of proper toothbrushing technique.

Findings. The FEELING GOOD series had no measurable impact of statistical significance in the dental care area. Data displayed are of three types: (1) preseries baseline measures; (2) mid-series behavioral trends; and (3) findings that are suggestive but not statistically significant.

Items for which no impact was suggested include the following:

1) Information/opinion items (stated in summary form)

   A. RAC Baseline Q6-d and RAC Posttest Q2-d: One should have asymptomatic dental examinations every six months.

   B. RAC Interim 3, Q4-a: Thoroughness of brushing teeth is more important than frequent brushing.

   C. RAC Interim 3, Q4-b: Adult teeth should last a lifetime. (See Table 67 for suggestive data from the NORC study.)

   D. RAC Interim 3, Q4-c: The proper way to brush is...

   E. RAC Interim 2, Q4: Between-meal snacks are bad for children's teeth.

2) Behavioral items (stated in summary form)

   A. RAC Posttest Q9-a; NORC Wave 2, Q1-b; NORC Wave 3, Q6-c; NORC Wave 4, Q1-c: Self-reports of recent asymptomatic dental examinations.

B. RAC Baseline Q 4-e; RAC Posttest Q 9-b; NORC Wave 2, Q 3: Use of dental disclosing tablets. (Although 6,000 viewers sent requests for disclosing tablets offered on one program, the two post-program measures indicated here did not find significant differences between viewers and nonviewers in use of such tablets.)

C. RAC Interim 3, Q 1-m: Use of dental floss.

D. RAC Baseline Q 8-c; RAC Posttest Q 5-c: Information-seeking on dental care.

Table 67 includes a suggestive effect on parents cutting down on sweet snacks for their children. Selected preseries or baseline measures from the RAC and NORC studies are presented in Table 66.

Table 66. DENTAL CARE: PRESERIES DESCRIPTIVE DATA (RAC AND NORC)

	RAC Baseline	NORC Baseline
Item:	Q 4-e	Q 57
Have you ever used a disclosing tablet? % yes:	(N = 5063) 28	(N = 368) 17
Item:	Q 4-a; 4-b	Q 58
Date of last asymptomatic dental examination . .	(N = 5063)	(N = 371)
% within last 6 months:	32	18
% 6 months - 1 year ago:	16	16
% never:	26	32

Table 67. DENTAL CARE: DATA SUGGESTIVE OF ATTITUDE OR BEHAVIOR CHANGE (NORC AND RAC)

NORC Wave 3, Q 4-t: Even if you see a dentist regularly, you cannot expect teeth to last a lifetime. (disagree)

Season A:	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
	Hi Viewer	Lo Viewer	Nonviewer	Nonviewer
Base N:	(66)	(97)	(46)	(85)
% disagree:	65	54	50	43

RAC Interim 2, Q 1-o: Since the middle of November, have you made an effort to cut down on the amount of cake, cookies, and candy, etc., your children eat? (yes)

	Viewers of Show A-5 (N=69)	Viewers A-6 - 8 but not 5 (N=54)	Nonviewers (N=338)
% yes:	51	43	36

Table 68. DENTAL CARE: TRENDS IN SELF-REPORTED BEHAVIORS (GALLUP AND RAC)

Gallup Survey #:	1	2
Field date:	12/74	2/75
Base N:	(1517)	(1544)
% Gone for asymptomatic dental examinations in last 2 months:	24	22

RAC Interim Measure #:	1	2	3
Field date:	12/74	1/75	3/75
Item #:	Q 4-a	Q 1-d	Q 1-d
Base N:	(518)	(466)	(411)
% Gone for asymptomatic dental examination in last 2 months:	26	22	25

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of dental care:

"I've made dentist appointments before because you are supposed to and now I do because I care."

"I learned of the availability of dental 'disclosing tablets.'"

"I learned to have the children's dental examination when they are younger."

"I now check on plaque more carefully and use dental floss more consistently."

"I watch sweet snacks like juice and cookies for myself and baby. I now use carrots etc., as snacks."

"I've really stressed on my children to brush their teeth more."

"I went for a dental checkup."

"Get my husband to a dentist!"

"I went to the dentist -- I didn't go since I was seventeen years of age and I went. When I saw the show 'Is you gonna have your teeth when you gets old?' I set to thinking about it so I up and went and that's something new for me."

"I realized the importance of your teeth even when you have no problems."

"I've taken the children to the dentist."

Stress

Rationale for choice of topic

Stress is produced by a variety of situations, many involving change -- for example, getting married or divorced, moving to a different neighborhood or city, getting a new job or losing an old one. Because many people are unaware that favorable changes such as a promotion produce stress, or that a series of small stresses can accumulate and cause physical problems, they may fail to engage in stress-reducing behaviors which could prevent health damage.

Behavioral goal

To motivate viewers to engage in stress-reducing behaviors when they find themselves in situations involving excessive stress.

Information to convey

1) Moderate levels of stress are beneficial in that they stimulate adaptive responses; excessive stress can lead to headaches, insomnia, ulcers, asthma, and hypertension.
2) Everyone experiences some amount of stress daily. Its source can be mental (such as a baby crying) or physical (such as a cold), but the mind and body are both affected regardless of the origin of the stress.
3) Tranquilizers relieve the symptoms of stress but do not affect its causes.
4) Learning to use the "relaxation response"--produced by a quiet place, comfortable posture, repetition of a sound or word, and a passive attitude--can reduce stress effectively.
5) Other adaptive means of handling stress are talking about

problems with someone close; working it off through a hobby or exercise; doing something for someone else; breaking problems down and handling them one part at a time.

6) If methods such as these do not help in controlling a person's mental and physical reactions to stress, professional help may be advisable.

Programming on stress

Season, program	Segment title	Running time	Format
B-6	"Stress" (program title)		
	Dick Cavett as host	3:19	host comments
	Cavett appears in opening, bridges, and closes to discuss the nature of stress and ways of coping with it.		
	"Stress Animation"	:50	animation
	Animated graphics are used to illustrate narration identifying situations which frequently involve stress--changing jobs, moving, getting married or divorced, etc.		
	"Medical Monologue"	3:57	comedy monologue
	Bill Cosby discusses the "fight or flight" reaction and other physiological effects of stress.		
	"Nancy's Life"	8:00	documentary
	Nancy, a young career woman, talks about the pressures and satisfactions of her work and caring for her son.		
	"Taps and Reveille"	1:12	"commercial"
	This take-off on TV ads for pep pills and tranquilizers shows a young man and woman who experience sharp mood changes after taking a new drug "available wherever better magazines are sold."		
	"Dr. Benson"	6:33	interview/ demonstration
	Dr. Herbert Benson describes the "relaxation response" which		

helps combat stress and demonstrates its use in an interview with Dick Cavett.

Other program elements	4:57	bridges, credits, referral, etc.

__Findings__. Five information/opinion items were addressed to the topic area of stress, with one of these items being asked in both the RAC and NORC studies. On two of the items, significant and/or suggestive impact of program B-6 was detected.

There was no impact on NORC posttest Q4-g: "Do you mostly agree or disagree: It is impossible to avoid stress in everyday life even if you are very careful." Overall, 77% agreed with the item, and the pattern varied little among treatment groups or viewing subgroups. Similarly, viewing or not viewing program B-6 had little impact on two RAC items, and their response distributions are presented in Table 69 for descriptive purposes only.

One interpretation of the descriptive data displayed in Table 53 is that program B-6 had an opportunity to teach the significance of accumulated stress from multiple "minor" situations, and simply failed to convey that message effectively. In the second displayed item, however, it is apparent that vast majorities recognized the value of talking problems through with another person; there was minimal room for additional impact, and indeed the viewing or non-viewing of program B-6 had little effect on the response patterns for that item. The use of tranquilizers was imbedded in the larger item above in the RAC study, but NORC asked the question separately, finding weak evidence of a viewing effect for program B-6, as displayed in Table 70.

Responses to an item about stress asked in both the RAC and NORC studies are displayed in Table 71.

__Conclusions__. There is somewhat equivocal evidence that program B-6 increased the proportions recognizing that stress can be helpful as well as harmful, and that taking tranquilizers is not a good way of dealing with stress.

Table 69. STRESS: DESCRIPTIVE OVERALL DISTRIBUTIONS ON TWO ITEMS (RAC)

	All Pretested Respondents (N = 3,705) %	Panel Control Respondents (N = 1,066) %
RAC Posttest Q15-b: No matter how many small stressful situations happen to you at one time, they can never equal the stress caused by one big thing, like losing your job. (mostly false):	44	53
RAC Posttest Q15-c: There are many things that people do to relieve stress. Which of the following things are good ways to deal with stress?		
-- work it off:	45	46
-- take a tranquilizer:	8	9
-- drink or eat something:	4	3
-- talk about the problem with someone:	84	85
-- push the problem out of your mind:	9	9

Table 70. STRESS: EFFECTS ON OPINIONS ABOUT TRANQUILIZERS (NORC)

NORC Wave 4 Q4-g: Taking tranquilizers is a good way of dealing with stress. (mostly disagree)

	Treatment Group A Induced to view & be interviewed		Treatment Group B Induced to be interviewed	Treatment Group C No inducements
Prog. B-6:	Viewer (N = 63)	Non-Viewer (N = 174)	Non-Viewer (N = 103)	Non-Viewer (N = 84)
% disagree:	86	80	73*	76

*significantly different from Treatment Group A viewers, $p < .05$, 1-tail

Table 71. PROGRAM B-6: SIGNIFICANT AND SUGGESTIVE EFFECTS ON OPINIONS ON THE FUNCTIONS OF STRESS (RAC AND NORC)

RAC B-Baseline Q2-b; RAC Posttest Q15-a; NORC Posttest Q4-c: Stress can be helpful as well as harmful. (agree)

RAC	Repeated Measure Respondents Season A pretest; Season A Interim Measure; Season B Posttest (N = 1,266)		Repeated Measure Respondents Season A Pretest; Season B Pretest; Season B Posttest (N = 2,439)		Panel Control Respondents Season B Posttest (N = 1,066)	
	Base N	B-Post % agree	Base N	B-Post % agree	Base N	B-Post % agree
Viewed Prg. B-6:	(166)	63	(269)	74	(146)	66
Viewed other shows:	(371)	54*	(692)	65**	(382)	57@
Nonviewers:	(729)	56	(1478)	62	(538)	53

(Significance of difference from B-6 viewers: *p < .05, 2-tail; **p < .01, 2-tail, @NS, but p < .07, 2-tail)

RAC Pre-Post Analyses

	Base N = Pretested Rs who did not agree on the Pretest	Proportion of Base N agreeing on the Posttest
	N	%
Viewed Prg. B-6:	(76)	48
Viewed Other Shows:	(196)	37@
Nonviewers:	(391)	34

(@NS, but p < .10, 2-tail)

NORC	Treatment Group A Induced to view & be interviewed		Treatment Group B Induced to be interviewed	Treatment Group C No inducements
Prg. B-6:	Viewer (N = 63)	Non-Viewer (N = 174)	Non-Viewer (N = 103)	Non-Viewer (N = 84)
% agree:	56	51	45	38

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of stress:

"The program aided me in ways to know how to deal with a severe emotional stress period that my 14 year old brother is going through. He is now in a hospital under observation."

"The program on stress when Dr. Benson talked with D. Cavett. The relaxation therapy was interesting and I've tried it."

"I've become more interested in meditation as a coping technique."

"Now I can live without tranquilizers; if I get stressful, I go and get a book to read or turn on the television or anything besids take a tranquilizer."

"I've learned how to cope with my grand kids a little better. And the show about this showed me how to get a different perspective on things now and then and how to calm down."

"I have more compassion for persons affected by depression and stress knowing the signs makes this possible. Prior to this I believed the person to be pouting or just plain 'ornery.'"

"I try to see that my husband relaxes more."

"I learned to overcome stress to keep you from having ulcers. That's one main thing I learned."

"I gained useful information about stress as my husband is having severe problems with it."

"I was not aware of the 'little things' that are stressful that can build up and have an effect."

"I learned that life is a series of ups and downs. The program helped my husband at a time when we had lost several close relatives and he had lost a job. After 35 years together, we found if we talked it out it was easier to accept and adjust to hurt."

"I've tried to have a little different attitude toward the tensions and stress in my everyday life. I try to do the little meditating thing."

Hypertension

Rationale for choice of topic 1 (hypertension checkups)

High blood pressure (hypertension) is a major factor in the development of heart disease, stroke, and kidney failure. It affects about 23,000,000 Americans, half of whom are unaware they have the problem because there are often no symptoms. It can usually be controlled through medication and diet.

Behavioral goals 1 and 2

1) To motivate viewers to have their blood pressure checked.
2) To motivate viewers to encourage others (friend, spouse, etc.) to have their blood pressure checked.

Information to convey

1) Hypertension is widespread, affecting 15-20% of the adult population. The rate among blacks is twice as high as among whites.
2) Hypertension can be asymptomatic -- i.e., you can have it without noticing symptoms. Half the people who have the problem don't know it. The only way to be sure you don't have it is to have a blood pressure check.
3) Hypertension checkups are quick, painless, and in some places can be obtained free.
4) Hypertension is treatable and in most cases can be brought under control in a brief period.
5) Maintaining control of hypertension is usually simple and entirely compatible with a normal life.
6) Uncontrolled hypertension can lead to serious health problems (heart disease, stroke, kidney failure).

7) Where viewers can learn how to obtain a free hypertension checkup.

8) Encouragement from friends and family members can help to overcome people's resistance to seeking diagnostic tests.

Rationale for choice of topic 2 (hypertension control)

An estimated 50% of those who are aware that they have high blood pressure are not under therapy. Many younger adults with hypertension do not regard it as serious, and a third are not aware that it causes other illnesses. A majority feel they are overweight but are not dieting; a majority have been told to eat less salt but many fail to follow this advice.

Behavioral goal 3

To motivate viewers who have been found to have hypertension to follow medical advice for controlling it.

Information to convey

1) Uncontrolled hypertension can lead to serious illness (heart disease, stroke, kidney failure).

2) Controlling hypertension helps reduce the risk of these other problems, but continuous treatment is essential. Taking medication or using other control measures for a time does not cure hypertension; there is no cure.

3) Although side effects of medication may occur occasionally, they are far less troublesome or serious than the consequences of failing to maintain a control regimen.

Programming on hypertension

Season, program	Segment title	Running time	Format
A-3, A-8	"Fred's High Blood Pressure"	1:04	"commercial"
	Middle-aged man is shown in a hammock, passing the day watching TV and eating, while narrator ironically notes that Fred's day is so busy he hasn't time to get his blood pressure checked. Final scene has Fred as an angel. Voice-over tag line is "Don't be an angel--get your blood pressure checked."		
A-3	"Sphygmomanometer Pitchman"	2:11	sketch
	Carnival pitchman who has trouble saying "syphygmomanometer" tries to sell passersby on the idea of having their blood pressure checked, noting that it is painless, quick, and sometimes free.		
A-3	"What Is Blood Pressure"	3:14	lecture/ demonstration
	Dr. Timothy Johnson explains what blood pressure is and takes a reading on a man who has never been checked for hypertension.		
A-3	"Something to Live For"	3:22	song
	The theme of this song by Joe Williams is that a parent has "something to live for," implying that caring for one's health enables a parent to see his children grow up.		
A-4, A-7	"Dice"	:30	"commercial"
	A visual with tumbling dice accompanied by narration which emphasizes that not taking medication for high blood pressure is like gambling with your life.		
A-8	"Keep Your Blood Pressure Down"	2:07	comedy sketch
	Bob and Ray in an "interview" between a talk-show host and the author of a book on hypertension. Basic information on blood pressure is interwoven with comedic elements throughout the segment.		
A-8	"Hypertension Graphics Film"	1:20	animation
	Graphics accompanied by narration make the point that hypertension may be present without producing symptoms.		
A-8	"When Rosie Died"	3:04	song
	Bill Withers sings a ballad about someone who died as a		

result of having hypertension. Emphasis is on fact that hypertension is easy to detect and usually can be controlled. A vox pop of people discussing hypertension is presented in the middle of the segment.

A-10 "Symptoms" 5:07 comedy monologue

Bill Cosby portrays two women conversing about their illnesses. One tries to explain to the other (who is convinced her symptoms are the world's worst) that hypertension may have no symptoms.

A-10 "Hush, My Baby" 4:15 song

Linda Hopkins, as a mother singing to her child, mentions an appointment to have her blood pressure checked and notes that "I can't take care of you, child, if I don't take care of me."

Findings. The NORC pre-series baseline measures indicated that:

1) 87% reported that their blood pressure had been checked within the last 12 months (N = 400);
2) 11% were told their blood pressure was high, 6% were told it was low, and 67% were told it was normal (N = 396);
3) 95% reported that a person could have high blood pressure and not know it (N = 400);
4) 53% claimed that someone had previously explained to them what a person with high blood pressure should do to control it (N = 398).

The RAC pre-series baseline measures (N = 5,063) indicated that:

1) 77% reported that their blood pressure had been checked within the last year;
2) 11% were told their blood pressure was high, 4% were told it was low, and 65% were told it was normal;
3) 44% wish they had been told more about their blood pressure at the time it was taken;

4) 48% reported that they had suggested to others that they get their blood pressure checked.

In measures taken during the series, ceiling effects were encountered on the informational item that a person can have high blood pressure and not know it: RAC Interim 1, Q3-b; RAC Interim 2, Q3-b; RAC Interim 3, Q3-c (where the item was phrased: It's sometimes hard to tell when you have high blood pressure); RAC Posttest Q2-f; NORC Wave 2, Q6-f; NORC Wave 3, Q-4n. In RAC Interim 2, the item was changed so that in addition to the general item described above (where 93% of the RAC Interim 2 respondents agreed that you could have high blood pressure and not know it), respondents were asked, "Which of these things almost always goes along with high blood pressure -- (1) getting red in the face; (2) losing your temper; (3) being nervous and tense; (4) having headaches; (5) none of these; and (6) I don't know." This question, believed to be more sensitive than the simple agree-disagree item, certainly did not show a ceiling effect: across all respondents, only 9% checked "none of these." The effect of program A-8 on responses to this question is indicated in Table 72.

The data displayed in Table 73 did not vary significantly as a function of viewing, but the response patterns for all respondents are interesting in their own right as descriptive data.

Season A programs A-3, A-8 and A-10 attempted to convey the information that blacks are particularly susceptible to high blood pressure. The impact of program A-8 on this item was not measured, but the other two programs were assessed in RAC Interim measures 1 and 3: the results are significant for the one and suggestive for the other, as displayed in Table 74.

Within the hypertension topic area, three behaviors were assessed: (1) information-seeking; (2) urging others to get blood pressure checks; and (3) getting a blood pressure check. Relevant data are displayed in the

Table 72. EFFECTS OF PROGRAM A-8 ON THE BELIEF THAT HIGH BLOOD PRESSURE IS ASYMPTOMATIC (RAC)

RAC Interim 2, Q 3-c: Which of these things almost always goes along with high blood pressure . . . (none of these). (Note: Although multiple responses were permitted, it is assumed that those checking "none of these" selected only that one option.)

	Viewed Program A-8	Viewed A-5-7 but not A-8	A-5,6,7,8 Nonviewer
	(N = 52)	(N = 71)	(N = 328)
% "none of these":	20	4**	8**

**Significance of difference from viewers of Show A-8: $p < .01$, 2-tail

Table 73. DESCRIPTIVE DATA ON THE PERCEIVED INCIDENCE OF 4 DISEASES, INCLUDING HIGH BLOOD PRESSURE (RAC)

RAC Interim 1, Q 10-a: About one out of every six Americans has . . .

	(N = 518)
	%
high blood pressure:	61
diabetes:	10
low blood sugar:	2
tuberculosis:	.3
don't know:	27

Table 74. EFFECTS OF PROGRAMS A-3 AND A-10 ON THE BELIEF THAT BLACKS ARE PARTICULARLY SUSCEPTIBLE TO HIGH BLOOD PRESSURE (RAC)

RAC Interim 1, Q3-a, and RAC Interim 3, Q3-b: High blood pressure occurs more frequently among black people than among white people (mostly agree).

Interim 1

	Viewed Prg. A-3	Viewed A1, 2, or 4 but not A-3	A1-A4 Nonviewer
	(N = 64)	(N = 62)	(N = 392)
% mostly agree:	39	22*	19

Interim 3

Pretested Rs

	Viewed Prg. A-10	Viewed A9 or A11 but not A-10	A9-A11 Nonviewer
Base N:	(61)	(57)	(285)
% mostly agree:	34	27	22

Panel Control Unpretested Rs

Base N:	(62)	(39)	(246)
% mostly agree:	38	36	19

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* Significantly different from viewers of Show A-3, $p < .05$, 2-tail

adjacent tables. In Table 75, information-seeking is analyzed as an overall series effect, as opposed to an effect of a particular program. RAC data (RAC Volume I, Table 3-15) were reconstituted to permit analysis of this question: Among those who had not sought blood pressure information in the six months preceding the series, what proportions did seek such information during the series, and how were these proportions associated with levels of viewing across the entire series? Small but significant differences were found as indicated in the table.

The behavior of urging someone else to get a blood pressure check was assessed in both the NORC and RAC studies, and both indicated a significant, positive effect, as displayed in Table 76.

On the behavioral goal of getting a blood pressure check, the NORC study found no evidence of an effect from either Season A (Wave 2, Q4; Wave 3, Q8) or program B-3, which dealt with the topic of heart attacks (Wave 4, Q2). The RAC study, however, found suggestive effects for Season A programming and significant effects from the series as a whole, as shown in Tables 77 and 78.

In Table 77, there are three groups of pretested respondents, all of whom would have been less prone than the unpretested panel control respondents to inflate self-reported behaviors because of telescoping. Proportions of pretested non-viewers reporting recent blood pressure checks held virtually constant across Interim Measures 1, 2, and 3. Proportions reporting recent blood pressure checks among those who viewed relevant Season A programming, however, increased steadily over time through one, two, and finally three programs related to high blood pressure. (For example, Interim 3 viewers of program A-10 had previously had the opportunity to see programs A-3 and A-8 as well, but their viewership/non-viewership of the previous relevant shows was not ascertainable in the Interim 3 measures.) The data are consistent

Table 75. INFORMATION-SEEKING BEHAVIORS ABOUT BLOOD PRESSURE (RAC)

RAC Baseline Q8-a, and RAC Posttest Q5-a: In the last six months, did you try to get information on where to get an examination for blood pressure for yourself or anyone else? (yes, I tried; no, I did not try; I already knew it)

	Base N = number responding "no" or "already knew" on the pre-series baseline measure	Proportion responding "yes" on the Posttest %
Hi Viewers (viewed 4 or more shows in the entire series)	(746)	9
Lo Viewers (viewed 1-3 shows in the entire series)	(908)	6*
Nonviewers (viewed no shows in the entire series)	(1,851)	4**

Significance of difference from the Hi Viewers: $*p < .05$, 2-tail; $***p < .001$, 2-tail

Table 76. OVERALL SERIES EFFECTS ON URGING OTHERS TO GET A BLOOD PRESSURE CHECK (NORC AND RAC)

NORC: Have you urged someone else to get a blood pressure check? (Wave 3, Q 9: Since we last talked; Wave 4, Q 3: Since March 1st)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed		TREATMENT GROUP C No Inducement	
Overall series viewing status:	High Viewer	Low Viewer	Viewed Some	Non-viewer	Viewed Some	Non-viewer
Wave 3 N:	(76)	(87)	(13)	(36)	(18)	(78)
% yes:	66	71	86	42**	67	33++
Wave 4 N:	(76)	(87)	(34)	(100)	(18)	(78)
% yes:	66	61	54	44**	56	27** +

**Treatment Group B Nonviewers significantly different from Treatment Group A High Viewers, p <.01, 1-tail. Significance of contrast between Treatment Group C Viewed Some and Nonviewer subgroups: + p <.05, 1-tail; ++ p <.01, 1-tail.

RAC: Have you ever suggested to someone else that they should get their blood pressure checked? (RAC Baseline, Q 3-e; RAC posttest Q 8-b) (yes, no, not sure)

	Base N = number saying "no" or "not sure" on the preseries baseline measure	Proportion responding "yes" on the Posttest %
High Viewers (viewed 4 or more shows in the entire series):	(353)	61
Low Viewers (viewed 1-3 shows in the entire series:	(497)	27**
Nonviewers (viewed no shows in the entire series):	(1,032)	26***

***Significance of difference from the High Viewers: p <.001, 2-tail

Table 77. SUGGESTIVE SEASON A EFFECTS ON GETTING BLOOD PRESSURE CHECKS (RAC)

RAC Interim 1, 2, and 3: (In the last two months) have you had a blood pressure check? (Q 1-b throughout)

Interim 1	Viewed Program A-3	Viewed A-1, 2, or 4 but not A-3	A-1 - A-4 Nonviewer
	(N=64)	(N=62)	(N=392)
% yes:	37	31	41
Interim 2	**Viewed Program A-8**	**Viewed A-5, 6 or 7 but not A-8**	**A-5 - A-8 Nonviewer**
	(N=52)	(N=71)	(N=328)
% yes:	52	44	43
Interim 3	**Viewed Program A-10**	**Viewed A-9, or 11 but not A-10**	**A-9 - A-11 Nonviewer**
Pretested Rs.			
Base N:	(61)	(57)	(285)
% yes:	63	56	42
Panel Control Unpretested Rs.			
Base N:	(62)	(39)	(246)
% yes:	63	58	51

Table 78. OVERALL SERIES EFFECTS ON GETTING BLOOD PRESSURE CHECKS (RAC)

RAC Baseline Q3-a, Posttest Q8-a: When, if ever, was the last time you had your blood pressure checked?

1. within the last 3 months
2. between 3 and 6 months ago
3. between 6 months and a year ago
4. between one and two years ago
5. more than 2 years ago
6. never had it checked
7. not sure

	Base N = Number of respondents checking codes 4,5,6, or 7 above on the pre-series baseline measure	Proportion of respondents checking checking codes 1, 2 or 3 on the posttest %
Hi Viewers (viewed 4 or more shows in the entire series):	(168)	57
Lo Viewers (viewed 1-3 shows in the entire series):	(191)	50
Nonviewers (viewed no shows in the entire series):	(506)	42***

***Significantly different from the Hi Viewers, p < .001, 2-tail

Table 79. BLOOD PRESSURE: DESCRIPTIVE INFORMATIONAL AND BEHAVIORAL TREND DATA (GALLUP AND RAC)

Gallup Survey #:	1	2	3	3	4	4
Field date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for last 2 months only:	X	X	X		X	
Q asked first for 6, then 2 months:				X		X
Base N:	(1517)	(1544)	(785)	(814)	(799)	(826)
% Reporting blood pressure check in last 2 months:	44	42	50------32		46------32	
RAC Interim Measure #:		1	2	3	3 (Panel Control)	
Field date:		12/74	1/75	3/75	3/75	
Item #:		Q 3-c	Q 3-a	Q 3-a	Q 3-a	
Base N (all respondents):		(518)	(466)	(411)	(353)	
High blood pressure... ...can lead to stroke, kidney disease and kidney problems %;		76	71	76	73	
...can easily (usually) be controlled with medication %:		70	83	82	83	

with the interpretation that Season A, which dealt with blood pressure in three separate shows, had a cumulative effect in motivating people to get blood pressure checks. Larger sample sizes would undoubtedly have permitted these effects to be determined statistically significant, but they are suggestive even in their present form. With larger samples, and with reference to a longer time duration, the same behavioral effect (getting a blood pressure check) was statistically significant on the RAC Posttest, as displayed in Table 78.

Trend data, displayed in Table 79, include not only national survey data from Gallup, but also an item used by RAC in all three interim measures that was neither suggestive nor significant when broken out by viewership patterns. The data presented here for descriptive purposes only.

Conclusions. Program A-8 had a significant impact on the proportions considering a list of plausible high blood pressure symptoms, who then judged that none of them applied. Other means of measuring knowledge of that asymptomatic nature of high blood pressure encountered ceiling effects.

Program A-3 had a significant effect on the proportions stating that blacks are particularly susceptible to high blood pressure. On this same measure, Program A-10 produced a suggestive but not statistically significant effect.

The series as a whole had a significant effect on the proportions seeking information about blood pressure tests.

Both the NORC and the RAC studies indicated that the series as a whole had a significant effect on the behavior of encouraging others to get a blood pressure test.

While the NORC study could detect no significant behavioral impact on getting a blood pressure check, RAC data were suggestive on this behavioral measure for Season A programming, and significant when considering the impact of the series as a whole.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of hypertension:

"I insisted a relative have her blood pressure checked -- as it turned out it may have prolonged her life."

"As a high school biology teacher I suggested to my students (all Black) that they watch the show and we took the blood pressure of each student. Two are now taking medication for this condition. They were not aware of the high incidence of hypertension in the Black population but assumed it was only in older people."

"I learned how to recognize possible high blood pressure. I had it checked several times since the program."

"I became more conscious of the importance of regulating blood pressure because of Pearl Bailey."

"I've gone on a diet and I've had my blood pressure checked."

"The statistical occurrence of hypertension and the lack of knowledge concerning the illness has caused me to speak of it to many people. I discovered mine twenty years ago."

"I've been more concerned about my high blood pressure. I had it checked."

"I sent my husband to have his blood pressure checked."

"I learned that there are no symptoms for high blood pressure."

"I learned about the importance of blood pressure tests. One should have regular medical checkups more often than I previously believed."

"My husband has become much more aware of his blood pressure problems and the need to do as directed by our family doctor."

Hearing

Rationale for choice of topic

Minor hearing difficulties afflict 10-15% of all children; in some inner-city areas, the prevalence is higher. Minor hearing losses (caused by ear disease and ear infections) which occur during critical periods for the development of speech and language (birth to age four) have long-range consequences; hearing disruptions during the first two years of life can lead to permanent learning problems. Most hearing problems are treatable or curable if they are discovered and treated before school age.

Behavioral goal

To motivate parents or others responsible for child care to take their preschool children for a hearing screening.

Information to convey

1) Most hearing problems are treatable (and/or curable) if they are detected before school age.
2) Children can have hearing problems which may not be noticeable to their parents (i.e., have no apparent symptoms).
3) Uncorrected hearing problems can have serious consequences for the child -- e.g., difficulty in learning to read, poor school performance, emotional problems.
4) Hearing screening is painless, takes only a few minutes, can be enjoyable for the child, and is not expensive.
5) Where viewers can find out how to arrange a screening.

Programming on hearing

Season, program	Segment title	Running time	Format
A-2	"The First Time" Film of children in various activities illustrates the lyrics of a song by Anne Murray ("..the first time I heard the band in the park, I stayed and I listened until it was dark.."). Middle part of segment shows children taking vision and hearing tests, and gives reasons why early tests are important. Segment closes with reprise of song and film. (This segment description also appears in the report section dealing with vision.)	3:43	illustrated song/demonstration
A-2	"What Kids Hear" Bill Cosby points out that children hear selectively; for example, they seem to hear "Who wants my dessert?" much more easily than "Clean up your room." The point is made that parents may be unaware that a child has a hearing problem, and thus that a hearing test should be obtained before school age.	3:45	comedy monologue
A-10	"Lend an Ear" A boy tries to communicate with an old man on a park bench. Because the man has a hearing problem ("All kids should have their hearing screened by age four" is understood as "Orchids should have their earrings creamed by Abe Fortas"), the message is repeated several times.	1:21	"commercial"
A-10	"Patty" Parents and friends of a preschool child named Patty discuss her hearing loss and the symptoms that led to the discovery of her problem.	8:12	documentary
A-10	"The World is Music" Johnny Mathis does a song ("All the world is music to my ears ... and I hear everything that comes along ...") which serves as a conclusion to the series of segments on hearing.	2:36	song
A-10	"Mathis Referral" At the end of his song, Johnny Mathis tells viewers that children with hearing problems miss a lot of the world, but that most hearing problems in young children can be treated and often cured. He suggests a screening before the age of four and introduces a "referral" for further information.	:21	lecture/referral

B-9 "And We Shall Sing"
(program title)

Dick Cavett as host	5:33	host comments

Cavett appears at several points throughout program to discuss importance of having hearing checkups and the adjustments required by persons who have hearing problems.

"Mr. Haber & Millie Goldstein"	19:25	documentary

Two separate stories are treated. One concerns nine-year-old Millicent Goldstein, who was born with severe hearing loss and is now learning to lip read. The other involves Mr. Morris Haber, deafened by a disease when he was 57 years old, who is also shown learning to read lips. The nature and consequences of their hearing problems are described, and the value of hearing screenings for young children is emphasized.

Other program elements	3:34	bridges, sound montage, referral, credits, etc.

NOTE: The evaluation does not include an assessment of the effects of program B-9, since this program was telecast after most data collection had been completed. Any findings in the area of hearing pertain only to Season A programming.

Findings. NORC preseries baseline measures among mothers of preschoolers aged four to six indicated that 45% of those children had already received a hearing test (N = 82). Of those not receiving such tests already, half the mothers indicated that they probably or definitely planned to do so; half indicated they probably would not (NORC baseline Q53 and 53-A). Of those intending to take their preschooler for a hearing test, only half of them had a particular place in mind for the test (NORC baseline, Q53-a-1). NORC measures taken during and after Season A found no viewing effect on the incidence of recent hearing tests for children (NORC Wave 2, Q2-c-2; NORC Wave 3, Q10-d-2).

RAC preseries baseline measures indicated that 31% of the parents of preschoolers had taken their oldest preschool child for a hearing check (RAC baseline Q20-c; weighted N = 3,210). Postseries analyses indicated that 35% of those parents who viewed any part of the series (N = 450) subsequently reported this behavior, while 29% of the series non-viewers did so. However, audience self-selection factors could account for those differences more plausibly than could series impact (RAC baseline Q20-c; RAC posttest, Q34-c). This interpretation is supported by RAC Interim Measures taken during Season A, where the incidence of recent hearing tests for preschoolers related more clearly to general viewing than to viewing of specific relevant programs (RAC Interim 1, Q1-q; RAC Interim 3, Q1-o).

As displayed in Table 80, there is weak evidence that Season A (logically, only program A-2) had a significant impact on one information/opinion item, while program A-10 had a highly suggestive but not statistically significant effect on another information item.

A suggestive but not statistically significant effect on information-seeking is displayed in Table 81.

Descriptive trend data on the reported incidence of hearing tests for adults and children are provided by Gallup surveys 3 and 4, as displayed in Table 82.

Conclusions. There was little demonstrable series effect in the topic area of hearing. Relevant programming in Season A did appear to increase the proportions of parents of preschoolers recognizing the difficulty of identifying hearing problems in children. A suggestive but not statistically significant effect of program A-10 was to increase the proportions of parents who were aware of the high incidence of impaired hearing in children. No behavioral impact was made on the incidence of taking preschoolers for a hearing test, but data are suggestive (not statistically significant) that the series as a whole had a modest impact on information-seeking behaviors for testing children's hearing or vision.

Table 80. CHILDREN'S HEARING: SIGNIFICANT AND SUGGESTIVE SEASON A INFORMATIONAL EFFECTS (NORC AND RAC).

NORC Wave 2, Q 6-i: Parents can always tell if their child has a hearing problem. (disagree)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed
Season A Viewing Status:	High Viewer	Low Viewer	Nonviewer
Base N:	(46)	(63)	(24)
% disagree:	76	46***	63

*** Significantly different from the High Viewer group, $p < .001$, 1-tail.

RAC Interim 3, Q 10: Nearly 1 in every 5 preschool children has less than normal hearing. (agree)

	Viewed Program A-10	Viewed A-9 or A-11 only	A-9 - A-11 Nonviewer
Pretested Respondents			
Base N:	(61)	(57)	(285)
% agree:	57	42	41
Panel Control Respondents			
Base N:	(62)	(39)	(246)
% agree:	58	40	42

Table 81. CHILDREN'S HEARING (AND VISION): SUGGESTIVE OVERALL SERIES IMPACT ON INFORMATION-SEEKING BEHAVIORS (RAC)

RAC Baseline Q 20-a and RAC Posttest Q 34-a: Have you ever tried to get any information on where to go to get your child's vision or hearing checked?

1 - No, I have not tried
2 - Yes, I have tried
3 - I already know where to go
4 - Someone else in the family takes care of these things

Decision rule applied to both pretest and posttest data: Yes = code 2; N = codes 1,3,4, and not reported.

	Base N = Number of parents of children under 6 who indicated "No" on the preseries baseline, as defined in the decision rule above	Proportion of parents of children under 6 who indicated "Yes" on the posttest
	N	%
High Viewers (viewed 4 or more shows in the entire series):	(194)	11
Low Viewers (viewed 1-3 shows in the entire series):	(213)	7
Nonviewers (viewed no shows in the entire series):	(439)	7

Differences between High and Low viewers, and between High and Nonviewers, approach but do not reach statistical significance.

Table 82. TREND DATA ON INCIDENCE OF HEARING TESTS FOR ADULTS AND CHILDREN (GALLUP)

Gallup Survey #:	3	3	4	4
Field date:	4/75	4/75	5-6/75	5-6/75
Q asked for 2 months only:	X		X	
Q asked first for 6 then 2 months:		X		X
Adult hearing test reported for last 2 months - -				
Adult base N:	(785)	(814)	(799)	(826)
Percent:	14 - - - - - -	6	13 - - - -	6
Child's hearing checked by doctor in last 2 months - -				
Base N Parents:	(392)	(411)	(375)	(397)
Percent:	20 - - - -	11	18 - - -	13

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of hearing:

"I started to put cotton in my ears to stop the noise because I work around machines and I stopped using Q-tips."

"I have a better understanding of the condition of my small grand nephew who was born with a hearing problem."

"The hearing program was very good and things to do if your child doesn't hear well."

"We saw the program on hearing defects and I feel it will help us in the future when we come to raise a family -- recognizing and dealing with hearing problems at an early age!"

"I learned the best time to have a child examined for defects in hearing."

"I plan to have ear examinations for my children plus for myself."

"I had my son's ears checked."

"I learned the age when the mother should take her children in for hearing tests."

Allied Health Personnel

Rationale for choice of topic

There is a significant shortage of physicians in the United States. For example, 140 counties have no physicians, and 55,000 people live in communities where health care is either inadequate or non-existent. The recent advent of allied health professionals (AHP) offers hope of relieving the shortage, but many people are unaware of the tasks which can be performed by allied health personnel and thus may be reluctant to accept their services.

Behavioral goal

No behavioral goal was developed for this topic.

Information to convey

1) Allied health professionals can perform many of the tasks formerly performed only by physicians -- e.g., taking patients' medical histories, performing physical examinations, giving immunizations, instructing and counseling patients.
2) Training of AHP can vary from three months to five years.
3) The allied health professions offer many career opportunities.
4) Where viewers can obtain additional information about allied health professionals.

Programming on allied health personnel

Season, Program	Segment title	Running time	Format
A-2	"W.C. Fields Sketch"	1:11	comedy sketch
	Reporter questions a Fields-type man on a park bench about allied health professionals. A small boy with him gives correct answers to the questions.		
A-2	"Sharry"	6:16	documentary

A day in the life of Sharry Erzinger, a Child Health Associate, showing her dealing with patients and their parents. Narration provides information about training and effectiveness of allied health professionals

A-11 "Inner City Clinic" 7:13 drama/documentary

Young man with few job prospects is treated in clinic and learns about training and opportunities for careers in allied health professions.

A-11 "Allied Health Wrap" 1:38 graphic

Moving list shows many career specialties in allied health professions.

A-11 "Pullin' Together" 2:45 song

Labelle, a singing group, does a song which implies that joining forces can get things accomplished. Intended to reinforce the message of the preceding segments.

Findings. The two Season A programs containing material relevant to this topic had no informational impact in the RAC Interim Measures:

1) RAC Interim 1, Q7-a; and RAC Interim 3, Q8-a: Over half the cases a doctor sees in a clinic can be treated by specially trained medical personnel who are not doctors. (mostly agree)

2) RAC Interim 3, Q8-b: Allied health professionals (such as medical technicians, health associates, and operation room technicians) must have a college degree to qualify for this type of job. (mostly agree)

On content similar to the first item above, NORC found statistical significance in Wave 2, not because high viewers agreed in greater proportions than RAC respondents, but because non-viewers disagreed in greater proportions. Data are displayed in Table 83.

Table 83. ALLIED HEALTH PROFESSIONALS: SEASON A INFORMATIONAL EFFECTS (NORC)

NORC Wave 2, Q 6-d: Much of the work a doctor does can be done by specially trained personnel who are not doctors. (agree)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed
Season A Viewing:	High Viewer	Low Viewer	Nonviewer
Base N:	(46)	(63)	(24)
% agree:	52	35*	25*

*Significantly different from High Viewer group, p.< .05, 1-tail

Conclusions. Majorities of RAC respondents agreed with the proposition that allied health professionals can handle many of the cases typically handled by doctors, and further increments could not be attributed to Season A programs. In the NORC study, however, only Season A high viewers had majorities of respondents agreeing with the proposition. The informational point, therefore, was successfully conveyed in the circumstance where majorities didn't already know it or agree with it.

Health Insurance

Many people are unaware of the qualifications and exclusions in health insurance policies, and as a result, fail to obtain the coverage they desire. One recent study showed that 30% of private hospital expenses, 57% of physician expenses, and 95% of other health care costs were not met by insurance payments and were paid for directly by the individuals concerned.

Behavioral goal

To motivate viewers to obtain information about the costs and benefits of health insurance plans before deciding which one to purchase.

Information to convey

1) Various health insurance policies may differ greatly in the benefits they provide. Prospective buyers of such insurance can sometimes obtain greater coverage at less cost by comparison shopping.
2) Policies which are identical in cost may differ in other important respects, such as exclusions, renewability, deductibles, and waiting periods.

Programming on health insurance

Season, program	Segment title	Running time	Format
A-6	"80% Covered"	4:10	comedy sketch
	Jerry Stiller and Anne Meara portray an elderly patient and an insurance clerk discussing medical coverage. The patient discovers to his dismay that his policy does not cover many of his hospital expenses.		
A-6	"Insurance Graphics"	1:59	animation
	Animated graphics are used to illustrate narration describing nine points to check before buying health insurance (renew-		

ability, family coverage, maximums, exclusions, deductibles, internal limits, premiums, waiting periods, continuity).

A-9	Mac's Place segments	3:40	situation comedy

Melba, a frequent visitor to Mac's Place, is given the job of purchasing health insurance for an employee association. A friend advises her to shop around, and to check the exclusions and fine print in a policy offered to her by an agent.

A-9	"Check It Out"	1:20	song

At Melba's Shape Shop, near Mac's Place, Jason and Melba do a song about checking things out before buying ("...Don't let the sweet talk fool you...don't let the big words confuse your eye...don't let the fine print rule you...you've got to look before you buy...").

Findings. The only assessment item pertaining to programming in this area was asked in the RAC study (RAC, Interim 2, Q 1-M): Since the middle of November, have you...asked for information on hospitalization or medical insurance? The proportion of viewers of show A-6 answering "yes" to this question was the same as for viewers of other shows (46%); this proportion was well above that for non-viewers (32%), but the difference is attributable to self-selection rather than to program effect.

Conclusions. No program impact was demonstrated in the area of seeking information about health or medical insurance.

Uterine Cancer

Rationale for choice of topic

Although uterine cancer mortality has declined in recent years, there are still an estimated 46,000 new cases and 11,000 deaths due to uterine cancer each year. This cancer could be dramatically reduced as a cause of death if every woman would have a Pap test annually. Almost 9 in 10 women are aware of the Pap test as a means of detecting cancer, but only about half (according to a recent national survey) report having had a Pap test during the past year.

Behavioral goals 1 and 2

1) To motivate women to have a Pap test.
2) To motivate viewers to encourage others (friend, spouse, etc.) to have a Pap test.

Information to convey

1) The Pap test is a simple, quick, effective means of detecting uterine cancer.
2) Every adult woman should have a Pap test annually.
3) If uterine cancer is detected and treated early, there is a high survival rate (78% at five years).
4) Encouragement from friends and family members can help overcome resistance to seeking diagnostic tests.
5) Where viewers can obtain additional information about how to get a Pap test.

Programming on uterine cancer

Season, program	Segment title	Running time	Format
A-5	"I Don't Have Time"	2:26	song
	Women of different ages and lifestyles, photographed in work or home settings, use a single excuse for not getting a Pap test: "I don't have time."		
A-5	"My Body"	4:14	documentary
	A woman doctor is shown giving a Pap test, and offers comments on the ease of the test and the high cure rate for uterine cancer when it is detected at an early stage.		

Findings. In general, high levels of knowledge and advocated behaviors were encountered in the topic area of uterine or cervical cancer before the series began.

In the NORC study . . .

. . .95% of all the women had heard of a Pap test (N = 400)

- . . .of those, 97% reported already having had a Pap test (N = 381)
- . . .70% reported having a Pap test within the last year (N = 370)
- . . .79% said they typically got a Pap test at least every year (N = 360)
- . . .94% knew that the Pap test was for cancer (N = 381)
- . . .66% reported that adult women should have Pap tests regularly; 36% said every six months (N = 381)
- . . .68% felt that chances of recovery from uterine cancer, given early detection and treatment, were very good (N = 399).

In the RAC study, among a weighted base N of 8,141 female respondents,

. . .98% had heard of a Pap test

. . .96% knew that the Pap test was for cancer

. . .89% had received a Pap test

. . .64% reported having received a Pap test within the last year

Table 84. UTERINE CANCER: SEASON A SUGGESTIVE INFORMATIONAL EFFECT (RAC)

RAC Interim 2, Q 12-c: Cervical cancer caught early has a cure rate of nearly 100%. (mostly agree)

	Viewed Program A-5	Viewed A6-8, not A-5	A5-8 Nonviewer
	(N = 69)	(N = 54)	(N = 328)
% mostly agree:	86	74	80

Table 85. UTERINE CANCER: NOVEMBER BASELINE TO JUNE POSTTEST COMPARISONS AMONG WOMEN WHO HAD NOT SUGGESTED A PAP TEST TO OTHERS BEFORE THE SERIES BEGAN (RAC)

	Base N = Number of women who had NOT recommended Pap tests to others before November, 1974	% Reporting on the June Posttest that they HAD recommended a Pap test to a friend or relative
High Viewers (viewed 4 or more shows):	(251)	41
Low Viewers (viewed 1-3 shows):	(320)	36*
Nonviewers (viewed no shows of entire series):	(703)	29**

Re-analyzed data derived from RAC Vol. 1, Table 3-21. Significance of difference from High Viewers: *p <.05, 2-tail, **p <.01, 2-tail.

Table 86. UTERINE CANCER: OVERALL SERIES EFFECTS ON RECOMMENDING PAP TEST TO OTHERS (NORC)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed		TREATMENT GROUP C No Inducement	
Overall series viewing status:	High Viewer	Low Viewer	Viewed Some	Nonviewer	Viewed Some	Nonviewer
Base N:	(76)	(87)	(34)	(19)	(18)	(78)
% Urging someone else to get a Pap test since March 1:	50	49	49	30**	44	31

**Significantly different from both the Treatment Group A "High Viewer" and the Treatment Group B "Viewed Some" respondents, p <.01, 1-tail

Table 87. PAP TESTS: DESCRIPTIVE TREND DATA (GALLUP AND RAC)

Gallup Survey No.:	1	2	3	3	4	4
Field Date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for past two months only:	X	X	X		X	
Q asked for past six then two months:				X		X
Base N (women only):	(768)	(765)	(387)	(412)	(4[illegible]7)	(417)
% reporting Pap test in past two months:	32	26	28----	12	30------	16

RAC Interim Measure No.:	1	2	3
Field Date:	12/74	1/75	3/75
Base N (women only):	(378)	(338)	(297)
% reporting Pap test in past two months:	28	28	28

. . .68% reported typically getting a Pap test at least once a year. Among all RAC baseline respondents (weighted N = 13,492), 6% reported that they had tried within the past six months to get information on how to get a Pap test.

These levels of preseries knowledge and behavior left little room on most measures for detecting an additional series impact. Unsurprisingly, there was no detectable impact on:

1) what a Pap test is for (RAC Interim 2, Q12-a; NORC Wave 3, Q4-i);
2) opinion that adult women should receive Pap tests regularly (NORC Wave 3, Q4-i; RAC Interim 2, Q12-b);
3) recency of getting a Pap test (RAC Posttest, Q35; NORC Wave 2, Q1-a; NORC Wave 3, Q6-d; NORC Posttest, Q1-a);
4) information-seeking on Pap tests (RAC Posttest, Q5-e).

A suggestive informational effect from Season A is displayed in Table 84.

There was an overall series effect on one aspect of the uterine cancer topic area: urging someone else to have a Pap test. As displayed in Tables 85 and 86, this was found in both the RAC and NORC studies.

Conclusions. Ceiling effects were encountered in most behavior and knowledge/opinion items on uterine cancer, making it impossible to register gains on these items. Program A-5 had a suggestive but not statistically significant effect in increasing the proportions agreeing that cervical cancer has almost a 100% cure rate when caught early. The one statistically significant result, found in both the RAC and NORC studies, was an overall series effect in increasing the proportions recommending a Pap test to someone else.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of uterine cancer:

"I suggested to my mother that she have a doctor give her a pap smear and an examination for breast cancer very soon."

"I had my first pap test. I am 21."

"I arranged for a pap test which I had failed to have for 18 months rather than the year's limit."

"I suggested to a young female student in my high school biology class that she have a pap smear as she was having symptoms that indicated a problem. She had a biopsy following the test and is now being treated for cervical cancer in the early stages. Hopefully, it will be cured."

"Have a regular pap test."

Immunizations

Rationale for choice of topic

Although immunizations are available for diphtheria, tetanus, whooping cough, polio, rubella, and measles, an estimated 33% of preschool children have not been fully immunized against these diseases. In inner city areas, almost 50% of the children in this age group are unprotected.

Behavioral goals

To motivate parents or others responsible for child care to take their children to a health care provider (doctor, clinic, health department) to:

--begin their immunization series against DTP

--complete their series of immunizations against DTP

--have them immunized against measles

--begin their immunization series against polio

--complete their series of immunizations against polio

--have them immunized against rubella

Information to convey

1) Immunizations can prevent the above-named diseases.
2) These diseases can have serious consequences.
3) Many children, particularly in inner-city areas, have not been fully immunized.
4) Immunizations need not be painful, very rarely have negative side-effects, and in some places can be obtained at little or no cost.
5) Where to obtain more information about how to have children immunized.

Programming on immunizations

Season, program	Segment title	Running time	Format
A-3	"Immunization vox pop"	:36	vox pop
	Children try to say the word "immunization" and tell what it means.		
A-3	"Whooping Cough"	3:18	comedy monologue
	Bill Cosby reminisces about the time his brother had whooping cough, and notes that shots are now available to prevent this and other contagious diseases.		
A-3	"All the Shots"	1:34	"commercial"
	Howard Cosell does narration over a film of successful basketball shots and asks parents to be sure that their children have "all the shots" for polio, rubella, and other named diseases.		

Findings. Substantial programming on immunizations was anticipated, but actual treatment was minimal because of the change to Season B. Thus of the total pool of 27 items devoted to the topic, 21 were asked only on the RAC or NORC baseline questionnaire. Of the remaining six items, two were part of the Gallup national surveys, and are reported as descriptive data; two showed no effect; and two suggested a trend toward a detectable behavioral effect, but fell short of statistical significance. Tables 88-90 display a synthesis of typical baseline data, suggestive behavioral effects, and descriptive trend data.

The RAC Interim 1 measures covered program A-3, in which the brief segment on children's immunizations was presented. Viewers of this program did not differ significantly from viewers of other shows in correctly selecting from a larger list the immunizations needed by children (RAC Interim 1, Q10-d; ceiling effects here), or in proportions taking a preschooler for immunizations since the middle of October (RAC Interim 1, Q1-o). Suggestive behavioral effects from the NORC study are presented in Table 89.

Table 88. PRESERIES PERCENTAGES OF RESPONDENTS REPORTING VARIOUS PREVIOUS IMMUNIZATIONS FOR THEIR OLDEST CHILD UNDER SIX YEARS OF AGE (RAC AND NORC)

	RAC Base = male or female parents with children under 6; (N = 3210) (weighted)	NORC Base = mothers or females responsible for health of children under 6; (N = 202)
DTP (diptheria, tetanus, whooping cough) % yes:	86	99
Rubella (German measles) % yes:	68	84
Regular measles % yes:	66	82
Polio (oral vaccine or other) % yes:	82	99

Table 89. CHILDREN'S IMMUNIZATIONS: SUGGESTIVE BEHAVIORAL EFFECTS (NORC)

NORC Wave 2, Q 2-b, and Wave 3, Q 10-c: Since we talked with you last, have you taken your oldest child under 6 for shots or immunizations?

Treatment Group:	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Season A Viewing Level:	High Viewer	Low Viewer	Nonviewer	Nonviewer
Wave 2, N:	(27)	(34)	(13)	
% yes:	36	15	23	
Wave 3, N:	(35)	(54)	(28)	(44)
% yes:	41	30	32	29

Table 90. TRENDS IN SELF-REPORTS OF TAKING PRESCHOOLERS FOR SHOTS WITHIN THE LAST TWO MONTHS (GALLUP)

Gallup survey number and date:	1 - 12/74	2 - 2/75
Base (parents):	(735)	(721)
% reporting yes:	23	15

Conclusions. The evaluation studies found only slight evidence of series impact (suggestive but not significant) in the area of immunizations. The opportunity for impact was limited by the high levels of pre-series knowledge and behavior, and by the fact that very little programming was done on this topic.

Colon-Rectum Cancer

Rationale for choice of topic

Colon-rectum cancer strikes approximately 100,000 people and causes about 48,000 deaths each year. Almost three out of four patients might be saved through early diagnosis and prompt treatment. The proctoscopic examination is the best means of early diagnosis of colon-rectum cancer.

Behavioral goal

To motivate viewers who are over 40 years old to have a proctoscopic examination.

Information to convey

1) Men and women over 40 years of age should have a proctoscopic examination annually.
2) Proctoscopic examination is the best means of early detection of colon-rectum cancer; since the disease in its early stages may produce no symptoms, people are frequently unaware that this cancer is present.
3) Almost three out of four patients might be saved by early detection and prompt treatment.
4) The potential benefits of the examination far outweigh the temporary discomfort it involves.
5) Where viewers can obtain further information about colon-rectum cancer.

Programming on colon-rectum cancer

Season, program	Segment title	Running time	Format
A-11	"Proctoscopes"	1:31	"commercial"

A middle-aged man whose old Army uniform still fits discusses remaining youthful past forty and the importance of getting a proctoscopic examination.

A-11 "Dr. Lathan: Proctoscopes" 2:17 lecture

Dr. William Lathan provides some facts about colon-rectum cancer and describes the examination which can detect it at a time when treatment can be very effective.

Findings. Two information/opinion items on colon-rectum cancer were asked in RAC Interim Measure 3. Neither item showed statistically significant results, but the data were consistently suggestive of a viewing effect (see Table 91). The behavioral goal was not measured.

Table 91. COLON-RECTUM CANCER: SUGGESTIVE INFORMATIONAL EFFECTS OF PROGRAM A-11 (RAC)

RAC Interim 3, Q7-a: Most colon-rectum cancers can be diagnosed by . . (a proctoscopic examination (multiple choice)

	View Program A-11	View A-9 or 10 but not A-11	A-9 - A-11 nonviewer
Pretested Rs			
Base N:	(41)	(77)	(285)
% correct:	76	59	55
Panel Control Rs			
Base N:	(35)	(66)	(246)
% correct:	71	65	54

RAC Interim 3, Q7-b: Nearly 75% of all deaths from colon-rectum cancer could be prevented with early detection. (Mostly agree)

	View Program A-11	View A-9 or 10 but not A-11	A-9 - A-11 nonviewer
Pretested Rs			
Base N:	(41)	(77)	(285)
% mostly agree:	92	85	79
Panel Control Rs			
Base N:	(35)	(66)	(246)
% mostly agree:	93	82	77

Other Findings

Physical Examinations

Although a number of program segments were designed to motivate viewers to obtain diagnostic checkups in connection with specific topic areas (such as prenatal care, hearing, vision, hypertension, colon-rectum cancer, and uterine cancer), no programming was developed to promote the seeking of general asymptomatic physical examinations. However, the first program in Season A dealt with this to some extent through Mac's Place (Mac, who hadn't seen a doctor in eight years, was advised by his friends to get a checkup). It was assumed that some of the topic-specific programming might indirectly encourage viewers to obtain a general physical examination, and seeking such an examination might also be regarded as a consequence of increased health awareness or concern generated by the series. Thus, some questions regarding physical examinations were included in the evaluation instruments.

Findings. Before the series began, both the NORC and RAC studies inquired about the timing of the respondents' most recent asymptomatic physical examination.

Results were:

	RAC (N = 5,063)	NORC (N = 398)
within the last year:	50%	58%
more than a year ago:	35%	22%
never:	11%	20%

The same questions were asked again on the posttest that followed those FEELING GOOD programs being evaluated.

Results were:

	RAC		NORC
	Pretested Respondents	Panel Control (not pre-tested)	(includes both pretested and unpretested respondents)
	(N = 3,705)	(N = 1,066)	(N = 465)
within the last year:	58%	55%	64%
more than a year ago:	31%	34%	21%
never:	4%	7%	14%

(RAC categories needed to bring total to 100% were "not sure" or not reported. A decision rule to consider these percentages as reflecting "never had a physical examination" would lead to the overall conclusion that over 10% of both research populations had never had a physical examination.

An insight into perceptions of the importance assigned to asymptomatic physical examinations in various socio-economic groups was afforded by RAC baseline Q6-a: "Do you mostly agree or mostly disagree with the following statement: Regular physical examinations are worthwhile only if something is wrong with the person." The overall N of 5,063 was subdivided into education subgroups (less than high school graduate, high school graduate, college). The low-education group was three times more likely than the high-education group to agree with the statement (30% among less than high school graduates vs. 10% among college graduates). The same relative proportions held at the end of the series (RAC Posttest, Q2-a).

One evaluation item attempted to assess impact of a particular FEELING GOOD program: RAC Interim 1, Q1-e asked whether respondents had encouraged someone else to have a physical examination in the last two months. No pattern of responses could be associated with viewership of program A-1.

The NORC analysis of the incidence of recent asymptomatic physical examinations by overall levels of viewing in Season A produced suggestive but not statistically significant results, as displayed in Table 92.

The RAC study analyzed the incidence of recent asymptomatic physical examinations by overall levels of viewing of the series as a whole, with significant results, as shown in Table 93.

Even with the reduced self-reported frequencies of physical examinations obtained in the Gallup two-question subsamples (Table 94), the proportions may be inflated. The examinations reported presumably include those obtained for job or insurance reasons (rather than only those obtained voluntarily), and some respondents may have reported any physician contact as a physical examination.

Conclusions. Among respondents in the RAC study who reported no physical examinations on baseline measures for the year preceding the series, significantly more high viewers than non-viewers of the series as a whole reported asymptomatic physical examinations during the year preceding the end of the series. NORC found that the proportion of persons reporting a recent asymptomatic physical examination was higher, but not significantly higher, among frequent viewers of Season A programming.

Table 92. PHYSICAL EXAMINATIONS: SEASON A SUGGESTIVE BEHAVIORAL EFFECTS ON GETTING ROUTINE CHECK-UPS (NORC)

NORC Wave 2, Q 1-c and NORC Wave 3, Q 6-h: Since we last spoke with you, have you had a routine physical check-up when nothing was bothering you and you didn't need one because of a job or anything like that?

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed	TREATMENT GROUP C No Inducement
Season A Viewing:	High Viewer	Low Viewer	Nonviewer	Nonviewer
Wave 2				
Base N:	(46)	(63)	(24)	
% yes:	15	11	4	
Wave 3				
Base N:	(66)	(97)	(46)	(85)
% yes:	30	24	20	24

Table 93. PHYSICAL EXAMINATIONS: BEHAVIORAL EFFECTS OF THE OVERALL SERIES ON GETTING ASYMPTOMATIC PHYSICAL EXAMINATIONS (RAC)

RAC Baseline Q2-c and RAC Posttest Q7: About how long ago did you have the last physical examination when nothing was bothering you, regardless of the reason for having it?

	Base N = respondents reporting their last exam, on the preseries baseline, to be longer ago than 1 year, never, or not sure	Proportion of respondents indicating on the posttest that they had gotten an asymptomatic physical exam within the last year
	N	%
Hi Viewers (viewed 4 or more shows in the entire series):	(377)	46.8
Lo Viewers (viewed 1-3 shows in the entire series):	(471)	41
Nonviewers (viewed no shows in the entire series):	(997)	35**

**Nonviewers significantly different from High Viewers, $p < .001$, 2-tail. (The Low Viewers were almost significantly different from the High Viewers, and would have been so considered under a 1-tail test.)

Table 94. PHYSICAL EXAMINATIONS: DESCRIPTIVE TREND DATA (GALLUP AND RAC)

Gallup Survey #:	1	2	3	3	4	4
Field date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for last 2 months only:	X	X	X		X	
Q asked first for 6, then 2 months:				X		X
Base N:	(1517)	(1544)	(785)	(814)	(799)	(826)
% Reporting asymptomatic physical, last 2 months:	34	28	31-----	18	32--------	21
RAC Interim Measure # :	1	2	3	3	(unpretested panel control)	
Field date:	12/74	1/75	3/75	3/75		
Base N:	(518)	(466)	(411)	(353)		
% Reporting asymptomatic physical, last 2 months:	26	31	22	33		

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of physical examinations:

"I went for a complete physical-for the first really complete one I ever have had, and found a bad kidney in time to save it."

"After watching the show I went and had a complete physical which cost me $118.00 -- but I don't regret it."

"I've been watching my boys' health more and myself like today I went to the doctor for a check-up."

"Although I've always believed regular check-ups were important, it was easy to skip these until a problem came up. Now I feel these are a must on a regular basis."

"Some preventive actions were put into use following the gain of knowledge about them. I also urged a family member to get an examination for high blood pressure, eye glasses, also a breast examination."

"I urged my family and friends to have blood pressure checks and go more frequently for complete medical check-ups."

"I persuaded my husband and father to get physical check-ups."

"I set up doctor appointments which I probably wouldn't have done."

"I made a gynecological exam for myself and signed up for breast exam and five year followup at St. Vincent's."

Health Interest and Information-Seeking

Although no programming was directed specifically toward encouraging a higher degree of interest in health matters, it was assumed that this might be a general consequence of viewing the series -- and that increased seeking of health information might be associated with higher interest. Several questionnaire and interview items concerning health interest and information-seeking were included in the Gallup, NORC, and RAC studies; the findings are presented below.

Health Interest

Findings. A group of NORC preseries baseline questions on general interest in health are displayed in Table 95 for descriptive purposes.

NORC repeated three of these baseline items on the posttest, analyzing posttest data by the overall (Seasons A&B) analysis model described in Chapter Two (two viewing levels in each of the three treatment groups). NORC also displayed Wave 1 baseline responses for each of the six subgroups, although, as always, the NORC analyses were posttest only. Reference to the baseline data, however, indicated that (high) viewers indicated greater health interest than (low) non-viewers on the three items, not only on the posttest, but on the preseries baseline as well. The greatest real gains seem to have been made in the proportions reading newspaper articles about health frequently, and discussing health matters with friends often, as indicated in Table 96.

Conclusions. Various measures indicated generally rather high levels of interest in health topics even before the series began. Those with higher preseries interest levels tended to be those who subsequently became heavier series viewers. Overall series viewing was thus associated with high health

Table 95. DESCRIPTIVE DATA ON PRESERIES HEALTH INTEREST (NORC)

	N	%
Q10: Do you read newspaper items about health . . frequently:	(400)	43
. . only occasionally:		35
. . hardly ever:		21
Q11: Have you read any magazine columns or articles about health or medicine in the last month? Yes:	(399)	64
Q12: Do you watch doctor series on TV -- such as Marcus Welby, Medical Center, or such programs of that sort		
. . regularly:	(397)	59
. .only occasionally:		31
. . hardly ever:		10
Q13: Do you watch television documentaries or specials dealing with health or medicine?		
. . most of the time they are shown:	(400)	40
. . only occasionally:		38
. . hardly ever:		21
Q14: In general, as far as you personally are concerned, do you feel there are - -		
. . too many stories (etc) about health:	(399)	2
. . not enough of them:		80
. . about right:		6
Q15: Do you have any books or pamphlets on health that relate to adults that you refer to when you or anyone else in your household gets sick? Yes:	(400)	49
Q16 (for households with children under 6) Do you have any books or pamphlets on health that relate to children only, that you refer to when a child gets sick? Yes:	(212)	48
Q17: When a leaflet concerning health is given to you, do you . .		
. . usually read it:	(399)	82
. . sometimes read it:		13
. . usually not read it:		4
Q18: How often do you discuss health matters with people you know?		
. . often:	(399)	55
. . sometimes:		38
. . never:		6

interest to some extent before the series, and to a greater extent after the series, particularly as indexed by the self-reported frequency of discussing health matters with others.

Table 96. HEALTH INTEREST: BEHAVIORAL
EFFECTS OF THE SERIES AS A WHOLE (NORC)

	TREATMENT GROUP A Induced to View and be Interviewed		TREATMENT GROUP B Induced to be Interviewed		TREATMENT GROUP C No Inducement	
Series Viewing:	High Viewer	Low Viewer	Viewed Some	Nonviewer	Viewed Some	Nonviewer
NORC Baseline Q 18 and Posttest Q 20: How often do you discuss health matters with people you know? (often)						
Baseline						
Base N:	(63)	(75)	(31)	(81)	(16)	(60)
% often:	62	55	55	53	56	52
Posttest						
Base N:	(76)	(87)	(35)	(100)	(18)	(78)
% often:	68	60	69	46** ++	72	50
NORC Baseline Q 10 and Posttest Q 18: Do you read newspaper items about health? (frequently)						
Baseline						
Base N:	(63)	(75)	(31)	(81)	(16)	(60)
% frequently:	46	37	68	38++	50	42
Posttest						
Base N:	(76)	(87)	(35)	(100)	(18)	(78)
% frequently:	55	45	60	39* +	67	36+

**Significantly different from Treatment Group A "High Viewers," $p < .01$, 1-tail. ++Significantly different from Treatment Group B "Viewed Some" respondents, $p < .01$, 1-tail. +Significantly different from corresponding "Viewed Some" respondents, $p < .05$, 1-tail. *Significantly different from Treatment Group A "High Viewers," $p < .05$, 1-tail.

Health Information-Seeking

Findings. This topic area is not tied to seeking information on any specific health matter, such as blood pressure or cancer; such topic-specific behaviors have been reported in their respective sections. General information-seeking items covered here are of several types: requesting information advertised on television, examining print materials on health information. There is also one item on inter-personal information seeking: NORC asked on the baseline (Q19) and again on the posttest Q21) "Have you ever asked a druggist or pharmacist for advice about what to do when someone in your family gets sick?" Baseline proportion saying "yes" was 61% (N = 400); posttest proportion saying "yes" was also 61% (N = 468).

Descriptive information and trend data on looking at articles or pamphlets about health are presented in Table 97. The RAC interim measures cannot logically be subdivided into viewership of particular programs, since any program conceivably could have motivated such information-seeking. Responses are subdivided, however, into viewers and non-viewers for that interim measure for descriptive pruposes.

All data profiles within a single methodology or format appear to be stable in Table 97, but there is considerable variation across methodologies or formats. As commented upon previously, Gallup was able to reduce assumed telescoping of responses by asking the question first for the past six months, then for the past two months. The RAC data, while internally stable, are considerably above either level of the Gallup data.

In Wave 3, NORC asked (Q6-i) if respondents had asked or written for some information about health that was offered on TV since the previous interview; 9% said yes (N = 309). Essentially the same item was asked on each of the three RAC interim measures. These data are displayed in Table 98 for

Table 97. HEALTH INFORMATION SEEKING: DESCRIPTIVE TREND DATA (GALLUP AND RAC)

Gallup Survey #:	1	2	3	3	4	4
Field date:	12/74	2/75	4/75	4/75	5-6/75	5-6/75
Q asked for 2 months only:	X	X	X		X	
Q asked first for 2, then 6 months:				X		X
Base N:	(1517)	(1544)	(785)	(814)	(729)	(826)
% Looked at pamphlet or article about health in last 2 months:	54	46	53-----	32	55-------	35

RAC Interim Measures 1, 2 and 3, Q 1-a: (In the last two months...) Have you looked at an article or pamphlet about health?

Rac Interim:	1	2	3	3 (Panel Control
Field date:	12/74	1/75	3/75	3/75
Base N:	(518)	(466)	(411)	(353)
% yes:	75	77	80	80
% yes for Viewers (N):	88 (141)	86 (138)	80 (118)	84 (101)
% yes for Nonviewers (N):	71 (377)	73 (328)	79 (285)	79 (246)

Table 98. HEALTH INFORMATION SEEKING: DESCRIPTIVE DATA ON SENDING FOR TV-ADVERTISED HEALTH INFORMATION (RAC)

(In the last two months, have you...) Sent for any health information that you saw offered on television?

RAC Interim:	1	2	3	3 (Panel Control)
Field date:	12/74	1/75	3/75	3/75
Base N:	(518)	(466)	(411)	(353)
Total % yes:	5	6	8	8
Viewers % yes (N):	8 (141)	14 (138)	14 (118)	16 (101)
Nonviewers % yes (N):	4 (377)	3 (328)	5 (285)	5 (246)

Table 99. HEALTH INFORMATION SEEKING: OVERALL SERIES EFFECTS ON OPINIONS AND BEHAVIOR (RAC)

RAC Baseline Q28 and Posttest Q3: Compared to 6 months or so ago, do you get a different amount of health information from radio and television than you used to?

	Base N=number of respondents stating on the preseries baseline measure that they get less now, get about the same now, get no information or are not sure	Proportion of Base N respondents who stated on the posttest that they get more information now than six months ago
	N	%
Hi Viewers (viewed 4 or more shows in entire series):	(369)	59
Lo Viewers (viewed 1-3 shows in the entire series):	(511)	39***
Nonviewers (viewed no shows in the entire series):	(1130)	24***

RAC Baseline Q 29 and Posttest Q 4: In the last six months, have you sent for any health information that you saw offered on television?

	Base N = number of respondents stating "no" or "not sure" on the preseries baseline	Proportion of Base N stating "yes" on the posttest
	N	%
Hi Viewers (viewed 4 or more shows in the entire series):	(746)	13
Lo Viewers (viewed 1-3 shows in the entire series):	(918)	5***
Nonviewers (viewed no shows in the entire series):	(1909)	3***

***Significantly different from Hi Viewers, P<.001, 2-tail all respondents, and then subdivided by viewers and non-viewers. While most of these viewer/non-viewer contrasts are statistically significant, they are difficult to interpret as reflecting series impact because it is impossible here to pull out the effect of self-selection biases. The data are therefore presented for descriptive purposes only.

A more rigorous analysis of viewing impact on requesting TV-advertised information is presented in Table 99 with pretest-to-posttest tracking of respondents in three levels of viewing, all of whom are referenced to their baseline behaviors.

Conclusions. Viewing the FEELING GOOD series had no demonstrable impact on the incidence of looking at print information about health, but significantly increased the proportions saying they now get more health information than formerly from television. Viewing the series also had a significant impact on the proportion of respondents who sent for health information offered on television.

Supplementary Information. In addition to the self-report data presented above, some indication of the effectiveness of the programs in stimulating viewer efforts to obtain additional information is provided by a tally of responses to the "referral spots" included in the series. The Season A programs and topics on which additional information was offered were as follows: program 1, prenatal care, mental health; 2, heart disease, vision and hearing screening; 3, immunization, hypertension, dental care, breast cancer; 4, patients' rights, alcoholism; 5, uterine cancer; 6, prenatal care; 7, nutrition, alcoholism; 8, hypertension; 9, prenatal care, nutrition; 10, hypertension, hearing; 11, doctor/patient communication, colon-rectum cancer, allied health professions. Each Season B program offered information on a single topic, in the following sequence: home care of the aged, alcoholism, heart attacks, vision, breast cancer, stress, doctor/patient communication, depression, hearing, adolescent development, alternatives to teenage drug and alcohol abuse, smoking, and weight control.

As planned, many of the PBS stations presented the name and telephone number of local health agencies in the 25-second interval for each referral spot; a single information source was broadcast nationally as a back-up for areas which did not localize the spots. Because the stations and local health agencies did not maintain a record of inquiries, it was not possible to obtain systematic data on local information-seeking stimulated by the programs. However, figures were available for several spots which were used only on a national basis. For example, the American Hospital Association received 2,800 requests for copies of "A Patient's Bill of Rights," mentioned on program A-4; the American Dental Association received 6,000 requests for a sample of disclosing tablets, offered in a one-minute "commercial" on program A-6; the National Health Council received 1,450 requests for a booklet on allied health careers mentioned on program A-11; CTW received more than 20,000 requests for a "Quitter's Kit" offered on program B-12 about women and smoking, and an additional 20,000 requests resulted from the rerun of that program. Other topics drew smaller numbers of requests, presumably for one or more of several reasons, such as less public interest, less program time, and perhaps less effective programming.

Some stations which localized the referral spots reported sizable numbers of calls (1,200 to 1,500 in New York City following programs on breast cancer and heart disease, for example), but many others reported very little response. Technical broadcast factors may have accounted for some of these differences, but a full explanation is not readily apparent. Inadequacies in the system of monitoring responses preclude a judgment regarding the effectiveness of the programs in stimulating viewers to seek further health information, but knowing this may lead to improved evaluation plans for future series.

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of health interest and information-seeking:

"I sent to the Cancer Society for information on breast cancer and to the Heart Association for information on heart attacks."

"I began using the health center on campus more this year than last year."

"I'm more attentive to the results and comprehensiveness of my annual physical examination which comes each spring. I watch more TV shows pertaining to the health and medical care."

"I realized that health agencies are to benefit the public and I utilized the mobile chest X-ray for the first time."

"The program was mentioned to several of the low-income people I associate with who in turn watched the show. They became more health conscious and receptive to going to the free county health clinic. Thanks."

"As a teacher I ordered material from the American Cancer Society and gave each of the female students a pamphlet showing how to do a breast examination."

"I learned of the different agencies to contact."

"I've learned more about what to do about myself, and where to go for help about my health."

"It caused me to pick up a few health pamphlets while at the library."

"I liked the viewpoints that they stress, the tips they give you, the telephone numbers they give you so if you have that problem you can get the pamphlets."

Fatalism/Control

The emphasis throughout the series on the value of preventive health behavior was intended to increase viewers' awareness that they can exercise a considerable amount of influence over their health. Although no programming made this point explicitly, the evaluation included an assessment of possible changes in feelings about the extent to which illness is inevitable rather than subject to an individual's control.

Findings. Three items designed to assess such feelings were asked on the pretest and posttest of both the RAC and NORC studies. Neither set of measures reflected a viewing impact, but the data are interesting for descriptive purposes, and are presented in Table 100.

Table 100. DESCRIPTIVE MEASURES ON FATALISM AND LOCUS OF CONTROL (RAC AND NORC)

	RAC			NORC	
	Baseline	Posttest		Baseline	Posttest
		Pre-tested	Panel Control		
Base N:	(5063)	(3705)	(1066)	(135/136)	(468)
No matter how careful a person is, he has to expect a good deal of illness in his lifetime. % disagree:	72	77	76	45	53
Being healthy is mainly a matter of how well you look after yourself. % agree:	83	82	80	94	94
There's not much a person can do to keep from getting sick. % disagree:	84	86	85	72	68

Some examples of viewers' comments (see p. 120) regarding things learned or done in the area of fatalism/control:

"The experience of watching has given us an increased awareness of the importance of regularity of check-ups and self-care."

"I learned that if you take care of your body it will take care of you. I've learned of some ways to do it by seeing programs."

"It gives you some great ideas on how to live longer taking good care of yourself."

"About taking care of my health. Well, exercise and the proper foods to eat and now to take care of your body in general."

"I learned to be more observant of my own health, body and how I should eat to take care of my heart, not get overweight. I should go to the doctor more often."

"Tried to improve on myself in many ways, about stress, being careful about cancer, and I'm going to have a pap test. I got a lot of good urges from it."

"Well I really liked what they are teaching us about our health and what and how to take care of ourselves. I really hadn't thought about all my health and what you should do till I watched FEELING GOOD."

"Well, I think generally the most important thing they had to say was when ever we feel symptoms of several diseases, we should go to the doctor as soon as we feel it."

"Well I learned the effect that different things have on the body. How alcohol affects the body, how to deal with stress, how to communicate better with doctor, how to look for symptoms of different diseases, what to do in some emergencies."

"Watching vitamins intake, sure to get exercise that's needed and I realize I need more fresh fruit and vegetables. It's changed my life a lot and now I know what to do and how to do it."

"Most of all is how to help my health do things to look out for me and my family's health. Learning to face reality, wanting to help yourself."

General Health Self-Assessments

To provide a context for specific items on health information and behavior, both RAC and NORC asked a general health self-assessment item for both pretests and posttests. These data are presented here for their descriptive value.

Findings. The RAC question asked for a self-assessment of health relative to the perceived norm, while the NORC question covered 11 health problems, asking whether the respondent or anyone in the household had ever had each problem. RAC data are displayed in Table 101, followed by the NORC data in Table 102.

The interesting thing in the RAC data is the small proportion perceiving their own health as below average or not as good as most. There is possibly an implication here for future mass media health education campaigns which could make use of a simple yet multi-dimensional self-test of general health, with normative reference points. To the extent that self-perceived need is a prerequisite motivator for learning and behavior change, it would seem desirable for campaigns to incorporate various means of increasing the precision and validity of these self-assessments.

The NORC data in Table 102 are rank-ordered according to the frequency of self-reported problems on the posttest measure. It would be worthwhile to pursue the question, via secondary analysis, of the possible relationship between experiencing a particular health problem and viewing, learning and behavior changes regarding relevant content in the FEELING GOOD series. (NORC found no differences in amount of viewing by whether or not a given health problem was reported, but possible effects of viewing on knowledge or behavior were not analyzed in relation to problems experienced.)

TABLE 101. GENERAL HEALTH SELF-ASSESSMENTS (RAC)

RAC baseline and posttest Q 1-a: All in all, would you say your health is... better than most (etc.).

	Preseries	Posttest	
	Baseline (N = 5063)	Pretested Rs. (N = 3705)	Panel Control (N = 1066)
% better than most:	42	44	42
% just about average:	46	44	42
% not as good as most:	7	7	8
% not sure:	4	5	8

Table 102. SELF-REPORTS ON THE INCIDENCE OF 11 HEALTH PROBLEMS (NORC)

Baseline Q: Did you or anyone else in your household ever have. . . .
Posttest Q: Over the last six months, that is, since the first of the year, have you or anyone else in your household had. . . .

	Baseline (N = 398/399) % yes	Posttest (N = 468) % yes
1. trouble with being very overweight or underweight:	28	35
2. a lot of trouble with the teeth:	36	30
3. high blood pressure or hypertension:	36	27
4. trouble with seeing, even with glasses:	27	22
5. trouble with hearing:	19	15
6. mental or emotional trouble:	8	11
7. heart trouble:	14	8
8. a tumor, cyst, or growth:	0	7
9. hardening of the arteries:	6	6
10. trouble due to too much drinking:	2	5
11. cancer:	5	2

A final set of RAC data is presented both for its descriptive interest and for its value in estimating the magnitude of a possible source of self-selection bias. On both pretest and posttest, RAC asked, "At any time over the past year, has your health or the health of someone else in the household caused you to worry"? Data are displayed in Table 103. There is no evidence that respondents with high levels of worry/concern about health were substantially more prone to view the series than their less-worried counterparts. (Shortages from 100% in the table are "not reported" proportions.)

Table 103. INCIDENCE OF CONCERN/WORRY ABOUT HEALTH BY VIEWING LEVELS (RAC)

RAC Baseline and Posttest, Q 1-b: At any time over the past year, has your health or the health of someone else in the household caused you to worry? (yes, a lot; yes, some; yes, a little; no worry at all)

	Pretest Baseline Rs	Posttest Pretested Rs		Posttest Panel Control Rs	
		View 1 or more shows	Series Non-viewer	View 1 or more shows	Series Non-viewer
N:	(5063)	(1758)	(1947)	(572)	(494)
% yes: (combined responses)	76	76	74	74	71
% no:	24	23	25	23	25

CHAPTER FIVE: EVALUATION ISSUES

In addition to the various constraints on purposive broadcasting imposed by the system, as discussed in Chapter Three, there are also constraints on the evaluation of such broadcasting. The demonstrable consequences of a series such as FEELING GOOD are the effects that can survive both sets of constraints. Among the limitations encountered in the process of evaluation are the following:

1) The amount of measurement that can be attempted is restricted by such constraints as maximum interview length and budgetary limitations. For example, six programs in Season B were not assessed at all, and several elements of other programs were not specifically evaluated. The "real" effects, therefore, could well be more than are demonstrable by the available data.

2) Some topic or effect areas are not measurable with rigor. There is considerable anecdotal evidence, for example, that one consequence of the utilization effort for the series was to bring local health agencies and organizations together in cooperative effort, in some instances for the first time. Such activities do not yield readily to quantification or interpretation through experimental logic. Series objectives in some topic areas, such as mental health, are difficult to assess through questionnaires.

3) The extent to which measured effects can be causally attributed to the series, rather than to extraneous influences, is limited by the difficulty of establishing a true field experiment. The practical limitations on implementing such a procedure in the

RAC four-city study, and the trade-offs involved in the NORC field experiment, were discussed in Chapter Two. The use of multiple designs and methodologies was itself one means of coping with the problem of isolating the effects of an effort that was a minute part (probably less than 1% in budgetary terms) of the national effort in health education.

As a measured effect can be subject to various interpretations, so can a measured non-effect. An apparent lack of effect could indicate that a program failed to communicate effectively, or it could be a consequence of one or more non-programatic factors, such as the following:

Ceiling effects: In some cases, pre-series knowledge or reported behavior was so high that gains would have been almost impossible to achieve.

Audience segmentation: The target audience for some topics (e.g., prenatal care) was so small that even if the desired effects were obtained in that audience, they could have been obscured by a lack of change in the total population studied. For topics affecting fairly large target groups (such as all women, or parents of young children), it was possible to isolate these groups in the analysis; for others, however, an excessive number of screening questions would have been required to identify the appropriate sample segment.

Contingency effects: Some recommended actions would not be appropriate unless a given problem existed (e.g., encouraging someone with an emotional problem to seek help), and some items asked on several data collection waves normally would be answered "yes" only once during a year (e.g., having a Pap test).

Viewer classification: Some persons classified as "high viewers" for Season A may not have seen a program on which a given topic was treated, and this would have depressed any viewer/nonviewer differences on items related to that topic.

Limited viewer exposure or attention: A related problem is that people who viewed part of a program may not have seen all of it, and thus may have missed a segment or "cluster" of segments dealing with a given topic. Distractions occurring during a program may also have produced the same effect.

Countervailing messages: In some goal areas (e.g., limiting sweet snacks for children), potential program impact may have been weakened or overcome by product advertising with much greater exposure and repetition than that afforded FEELING GOOD.

Time period of effects: A recommended health action, such as obtaining a checkup for hypertension, may be delayed by appointment scheduling or other factors and thus not be included in the measurement interval following a given program or set of programs.

Threshold effects: If a gain is achieved on a given dimension (e.g., increasing awareness that one is susceptible to a specified health problem) which still leaves the individual below a level which would produce action, the effect may not be visible. For example, if a 90% level of risk perception is required, raising this level from 50% to 80% would not register as a gain on a behavioral measure.

Item quality: Some of the interview and questionnaire items used to assess program impact may have been inappropriately worded, included too few response categories, or had other weaknesses which limited their ability to detect significant effects.

Some comment may be in order as to the general "quality" of the evaluation data for FEELING GOOD. All data are subject to various forms of error, and all evaluation designs involve compromises of some kind. In their reports to CTW, the individual research contractors have discussed at length the various forms of error to which their data are susceptible. Although impossible to order with precision, the following seem to be among the more important issues (weaknesses and strengths) concerning the evaluation program as a whole.

1) The most serious evaluation problem was generated by the changeover to Season B after a coordinated evaluation program had been initiated under Season A assumptions. This was discussed in Chapter Two.

2) There is apparent inflation in some behavioral self-report measures, generally attributed by the contractors to "telescoping"; i.e., including behavior from a longer time interval than was called for in the question. One of the benefits of

the sub-experiment with split samples in the Gallup surveys was the demonstration of this effect and some estimate of its magnitude. The Gallup data were also reassuring that the inflation factor had minimal effect on the *relationships* among items. The caveat has been expressed repeatedly in Chapter Four that RAC behavioral self-report data which appear inflated (typically of the "Have you done X in the past two months?" variety) should be interpreted only in terms of relative effects instead of being interpreted as indexing absolute levels of behavior.

The original evaluation plan featured a compensatory strength to deal with the potential inflationary biases of self-report behavioral data: the NORC community monitoring study was to note the relationship between behavioral self-reports and requests for services at several points in the health care delivery system. Unfortunately, the community monitoring study could not be completed because appropriate records and data were not accessible. The logic of the original evaluation plan is still sound, however. One implication is that future evaluations should commit more resources and lead time to overcoming the barriers to obtaining behavioral observations for comparison with behavioral self-reports.

3) The repeated and predominant three-step data progression obtained with RAC respondents (1--viewed show X; 2--viewed other shows but not show X; 3--nonviewer) supports the decision rule to interpret viewing effects as the contrast between viewers of X and viewers of shows other than X. Repeatedly, significant

differences could have been found by contrasts with nonviewers, but were not calculated, because of the self-selection bias control offered by the more conservative measure. The extent to which all self-selection is accounted for (or perhaps even overcompensated for) by this decision rule is unknown.

4) The value of obtaining pre-post change measures must be weighed against the costs of possible changes in the respondents as a function of being measured. In the RAC study, pretest sensitization seemed to have been more of a problem in the assessment of Season B than of Season A. In the NORC study, this was judged not to be a significant problem. A strength of the designs was that the magnitude of possible panel effects could be estimated in both studies.

5) The major methodological issue in the NORC study stemmed from the lack of experimental control over actual viewing behavior, thus requiring posterior-defined viewing sub-groups within the a priori-defined treatment groups. Given the objective of assessing the impact of a series of Season A's design on an adult population known in advance to be difficult to reach with purposive public television, no clearly-superior alternative is readily apparent even after the study. Under different assumptions, as with the single-topic programming employed in Season B, it is apparent that greater analytic control is possible with shorter measurement intervals and tracking of show-specific viewing.

6) While it is certainly not advocated that programming be structured so as to provide maximum convenience for evaluation,

the consequences of programming in a very difficult-to-evaluate pattern should be recognized. The programming design for Season A (multiple topics and target audiences to be reached per show, along with variable rates of content repetition to be spread throughout the series) presented an especially difficult evaluation task, since expectation of an effect was only reasonable for those exposed to the relevant programming segments (and, ideally, exposed several times to the same point through a combination of repeated treatments and repeated viewing). By comparison, the evaluation of Season B was relatively simple. Had the Season B single-topic structure been planned from the outset, it might have been possible to devise more powerful designs than those developed to handle the mid-season changes.

7) To what extent did the evaluation measures match the programming? The interviews and questionnaires used provided fairly complete coverage of information points in the programs included in the evaluation, but about a third of the behavioral goals were not assessed. This was true for several reasons:

   a. Measurement of some goals would have required several screening questions in order to identify the target population; e.g., the goal "To motivate persons in high-risk categories for heart disease to have a medical checkup" would have entailed asking each respondent about age, weight, smoking habits, blood pressure, exercise, stress, diet, and family history of heart problems.

   b. Some goals were added or modified as the series progressed, so that original baseline measures were no longer applicable.

c. Measures regarded as adequate were not developed for some goals which were relatively non-specific (e.g., "To motivate parents to prepare their children for any significant change in their life situation") or which involved multiple actions (e.g., "To motivate viewers to avoid circumstances which commonly lead to burn injuries").

Now that the complete series content is known, it would be possible to develop more satisfactory measures and to insure that all important goals are covered. The implication for future programs is that evaluators should have the full content in advance if at all possible.

8) The initial evaluation strategy to employ varied and complementary evaluation techniques is seen in retrospect as a good decision, and one that should be considered in future evaluation efforts.

9) Some consideration must be given to the instances in which ceiling effects were encountered, making additional gains very difficult to produce. Extensive efforts were made during the developmental phases of the project to collect information on target audiences, including knowledge levels, health needs, and barriers to advocated behaviors. There are several reasons why so many ceiling effects were nevertheless encountered:

a. In many instances relevant audience information could not be found, or, if available, it was incomplete (particularly with regard to barrier analysis), out of date, conducted in a limited site or from a select population, and hence not generalizable.

b. In some cases only a proportional minority of "true prospects" was anticipated, but the small proportion was nevertheless large in absolute numbers, and sometimes concentrated in a significant demographic category of the target audience (e.g., low income).

c. In most cases the ceiling effect was informational, not behavioral. There is considerable evidence that awareness of a problem and knowledge of what should be done about it are not sufficient conditions for predicting corrective behavior change.

d. In some cases, the health experiences and perceptions of the creative writing staff may have differed greatly from those of the intended target audiences.

e. Not all information in the series was intended to be new to viewers. Some points served as reminders or reinforcing messages for people who already had the information but were not acting on it.

The retrospective analysis of these ceiling effect issues does imply a different procedure for comparable future experiments. When the precise audience information needed by research and production is not available, it should be collected at the beginning of the project. A special planning survey, conducted among primary target audience groups, directly targeted to decision-making needs, and covering both scheduled and possible health topics, would have been enormously valuable in the developmental stages of the FEELING GOOD project (Phase II). Given the ever-present limitations of evaluation funds, such a planning survey would have to rank competitively with the payoff of a pre-series baseline measure, which comes too late to serve effectively during planning.

10) The strategy employed by RAC to cope with expected low PBS viewership is worthy of note. With simple random sampling, it is possible to spend evaluation resources on 100 contacts only to net two or three viewers of a PBS program. This is very inefficient, and research funding is very unlikely to allow simple expansion of the sample until an adequate viewer base is obtained. RAC spent a considerable portion of their budget, even before the pre-series baseline measure, just to stratify a large (22,000) random sample of respondents into levels of likelihood of viewing the series. By oversampling from the high-likelihood stratum, the subsequent efficiency was increased dramatically while still retaining population representativeness through statistical weighing procedures. The stratification step greatly increased the subsequent ratio of viewers to nonviewers in the sample. Even though costly, the stratification step saved money in the long run, and this conclusion may be of value to others conducting research on relatively small subsets of the general population.

11) Since one implicit purpose of the series was to stimulate viewers to seek additional information about the topics treated, an accurate count of responses to the "referral spots" used on the programs could have provided an objective measure of impact in this regard. As a supplemental part of the evaluation,

tallies were obtained and reported for those instances where a single address was used nationally. However, inquiries to local agencies were not recorded systematically by the agencies or by PBS stations. A count of inquiries would not have been directly comparable to self-reports of information-seeking (and thus would not have provided a check on their validity), but the data would have been useful in their own right. Whether such data should be collected in future evaluations of national programs will depend upon a weighing of their potential value against the considerable cost of monitoring inquiries in a number of cities.

12) Although the summative evaluation of FEELING GOOD was far more extensive than most appraisals of health education efforts or purposive television programming, it was still limited in important ways. The evaluation did not include an assessment of the impact of the programs or activities related to them on PBS stations, health agencies, communities, or health professionals. It did not attempt to answer a number of process questions regarding the preparation of the series, involving such matters as the selection of topics and goals, the background of production personnel, limitations on the use of formative research findings, the types and amounts of "entertainment" program material vs. the types and amounts of informational or motivational material, the selection of guest stars, the number of goals per program, the format of the programs, the choice of time slot for broadcasts, the kinds and amounts of promotion used, and many others. Perhaps more importantly, the evaluation did not address the cost-effectiveness

question in an experimental way--comparing the results produced by FEELING GOOD with results produced by other forms of health communication, or by non-educational efforts involving applications of law or technology.

These are all significant questions, and means of answering some of them are proposed in Chapter Six. The evaluation conducted was designed to assess the series in terms of its own objectives--primarily, to induce viewers to take actions which could improve their own or their families' health. In order for the series to do this, it was necessary first to attract an audience and in some cases to convey information or to change attitudes, and such "instrumental" or intermediate objectives were also included in the evaluation. Entertainment programs on television are judged by the size of audience they attract, educational programs by the amount of information they convey, and commercials by the number of people they induce to take a recommended action. Unlike these other kinds of programming, FEELING GOOD was assessed on all three grounds.

The fact that this evaluation was not designed to answer questions as to whether the series should have been undertaken or how it might have been improved should not be taken to imply that such questions are unanswerable or undeserving of attention. The answers will necessarily be somewhat limited, however, unless they are based on a range of data permitting comparisons of two or more types of programs. The cost of the FEELING GOOD summative evaluation was about 5% of the total budget for the series--a very large amount in absolute terms, but certainly not sufficient to allow for parallel evaluations of other efforts to provide a reference point for judging the impact of this series. Evaluations of future large-scale social action projects could produce more definitive findings if comparative data were available; in the present case, such data would provide a useful (and for some questions, necessary) supplement to the kinds of findings reported here.

CHAPTER SIX: RESEARCH AND POLICY EXTENSIONS FROM THE FEELING GOOD EXPERIMENT

Introduction

A case will be made here for two propositions:

1) the summative evaluation data that now exist could yield many additional insights if supplemented by extended research and secondary analyses; and

2) the collective experience with FEELING GOOD, which goes well beyond elements that could be quantitatively evaluated, can make contributions, but cannot by itself provide definitive answers, to several general policy questions and issues concerning

    a) health education

    b) use of goal-directed television

    c) evaluation of social action programs.

Both propositions extend the scope of investigation beyond the mission of this summary report, which has been directed primarily toward the summative research function of comparing goals with outcomes. Because the FEELING GOOD series ranks among the most ambitious and thoroughly evaluated efforts to direct health education programming to the in-home television audience, there remain unique opportunities for future utilization of what has been and can be learned from this experiment. The purpose of this chapter is to suggest some of these possibilities.

Research Extensions

Six research projects, each extending the utility of the present summative evaluation data, are suggested below. This listing is not exhaustive, but it does illustrate the range of opportunities.

Relating formative research measures and summative evaluation. There is considerable opportunity for developing principles and models for health education campaigns in the integration of the currently-reported summative evaluation with a large body of data not reported here--the formative research effort that was conducted for in-house planning, and is not at present formally written up or publicly available. Most of the raw data are still available, and could be organized formally and analyzed much more thoroughly. The data are of interest in their own right, but it is their potential correlation with summative research outcomes that holds perhaps the greatest promise of a significant contribution to health education. Tables 104 and 105 summarize the characteristics of various formative studies. Table 104 indicates that on 20 of the 24 FEELING GOOD programs, formative research data on such factors as appeal, topic interest, and immediate post-test knowledge gain have been collected. It is the potential of these data to help explain the differential impact of various segments and programs (as measured in the summative evaluation) that is being stressed here, although many other analyses would also be of value.

Relating production elements to response measures. An extended analysis of FEELING GOOD should include a rigorous content analysis of the series to allow a comparison of the various production techniques and influence strategies with their respective outcomes in both formative and summative evaluations. While the possibilities here for theoretical insights transcend the evaluation of FEELING GOOD, this type of research should be viewed more as an effort to generate useful hypotheses than to produce firm conclusions. With many different variables converging in each program segment, it would be difficult to ascertain the value of any single element. However, to the extent that variations within production categories could be shown to relate to variations within outcome categories in a patterned fashion, there would be a reasonable basis for inferring working principles that could be useful to future programming efforts. FEELING GOOD is one of the very few television series with the data potential for relating content analysis measures of production elements to formative measures of appeal and comprehension, and then to summative measures of informational and behavioral outcomes. While this does not promise a generalizable "formula," it does offer more guidance to future production decisions than is otherwise available.

Following are some examples of questions which could be addressed by combining a content analysis of programs with the formative and summative data now available:

- What was the relative appeal of various production formats (dramas, interviews, songs, lectures, etc.) for different kinds of audiences?
- Which production formats were most effective in conveying information?
- Which production formats were effective in motivating behavior?
- What characteristics distinguished the relatively effective segments using a given format from ineffective segments using the same format?
- What kinds of appeals (e.g., parental role responsibilities, avoiding pain or disability, saving costs of treatment, maintaining vigor) were most effective in motivating preventive health behaviors?
- What forms of humor were most and least effective in conveying health messages?

Table 104. FORMATIVE RESEARCH FOR FEELING GOOD : CHARACTERISTICS OF STUDIES

Material Viewed	N	Material Distribution Methods	Data Collection Methods	Factors Studied	Designs Used
"VD Blues, "I Am Joe's Heart", "National Health Test", PSA's	604	CCTV, 16mm film	Questionnaires, group interviews, observation of viewers, program analyzer	Knowledge gain, segment appeal, overall reaction, perception of performers	Pre-post, Solomon 4-group, post-only, simultaneous viewing & responding
CTW Sample Reel	467	CCTV	Questionnaires, program analyzer, group interviews, personal interviews, observation of viewers	Segment appeal, cast appeal, segment credibility, knowledge gain, topic interest, overall reactions	Pre-post, post-only, simultaneous viewing & responding
CTW Pilot Show	1,910	CCTV, on-air broadcast	Questionnaires, program analyzer, observation of viewers, telephone interviews, observation of behavior	Knowledge gain, segment appeal, cast appeal, voluntary viewing, behavioral response	Pre-post, post-only, simultaneous viewing & responding, controlled field experiment
7 one-hour "Feeling Good" shows	655	CCTV, on-air broadcast	Questionnaires, program analyzer, group interviews, observation of viewers	Appeal, knowledge gain, perception of information, topic interest	Pre-post , post-only, simultaneous viewing & responding

Table 104. (Cont'd.) FORMATIVE RESEARCH FOR FEELING GOOD : CHARACTERISTICS OF STUDIES

Material Viewed	N	Material Distribution Methods	Data Collection Methods	Factors Studied	Designs Used
4 Constructed Reels	478	CCTV	Questionnaires, program analyzer, group interviews, observation of viewers	Appeal, knowledge gain, perception of information, motivational effect of various themes	Pre-post, post-only, simultaneous viewing & responding
13 half-hour "Feeling Good" Shows	1,986	CCTV, on-air broadcast	Questionnaires, program analyzer, group interviews, observation of viewers	Appeal, knowledge gain, perceptions of information, topic interest	Post-only, simultaneous viewing & responding

Table 105. SPECIAL STUDIES FOR FEELING GOOD

Study	N	Methods of Data Collection	Factors Studied	Design
Laugh track effects	319	Questionnaires, program analyzer	Laugh track vs. non-laugh-track versions of edited sample reel: segment appeal, cast appeal, moment-by-moment appeal, comprehension of information points	Treatment vs. control with matched sub-samples
Title options	519	Telephone interviews	Reactions to proposed titles for series	Single survey
TV viewing preferences	1,208	Personal interviews	Reported viewing of selected programs on public and commercial TV	Single survey
Topic and theme interest	571	Telephone interviews	Interest in viewing programs proposed for health series	Single survey
Topic interest	1,975	Questionnaires	Interest in health topics and program descriptions	Single survey
Health knowledge	1,188	Questionnaires	Knowledge of selected health topics	Single survey
Health beliefs and actions	Various (400-5,063)	Personal interviews, telephone interviews, mailed questionnaires	Beliefs and actions regarding selected health topics	Five surveys
Immunization messages	34	Questionnaires	Reactions to varied levels of threat in a message on immunization	Post-measure experiment

Table 105 (cont'd). SPECIAL STUDIES FOR FEELING GOOD

Study	N	Methods of Data Collection	Factors Studied	Design
Host options	147	Questionnaires	Appeal of potential hosts for Season B	Single survey
Viewing check	584	Telephone interviews	Awareness and viewing of series and single program; viewer characteristics	Coincidental survey
Smoking show	171	Mailed questionnaires	Reactions to show B-12 (smoking), comparison of Seasons A and B, perceptions of appropriate audiences for series, preferences for day and time of broadcasts	Single survey

- What was the relationship between the perceived amount of new or useful information in a segment and the appeal of that segment?
- What types of performers (e.g., lay person, physician, celebrity) were most effective in conveying health messages?
- Within each type, what characteristics distinguished relatively effective performers?

Secondary analyses. These are some of the major opportunities for extended analyses of the summative evaluation data:

1) Tracking of selected subpopulations. As one of several possibilities, NORC data can locate respondents who reported some specific health problem that occurred during the series. The question to be pursued would be the possible relationship between experiencing a specific health problem and viewing of programs about that problem, as well as learning or changing behavior as a consequence. Other possibilities include special analyses of any demographic subgroup in the NORC or RAC data pool.

2) A more precise analysis of Season A show-specific effects should be considered for the NORC respondents who are at present analyzed only by viewing level across all 13 programs (high viewer, low viewer).

3) An informal content analysis (no intercoder reliability checks) has been done on the NORC free responses and part of the RAC free responses. The potential utility of these responses would be much greater if coded for computer analysis so content analysis categories could be associated with previously-given responses to the interviews or questionnaires.

4 4) The large RAC screening sample (N=22,120) was used for pre-series stratification of respondents into levels of likelihood of viewing. The items used to predict likelihood of viewing could now be tested against actual reported viewing. The predictive test as a whole or any item or combination of items could thus be analyzed for its value in predicting viewing. The ability to predict audience size for upcoming purposive public television programming would be of great benefit to the PBS community. The actual performance of this predictor and its possible generalization should be explored.

Comparisons with other programs. FEELING GOOD has been evaluated formatively and summatively against its own goals and expectations. An independent research organization might make a valuable contribution with a multi-dimensional comparison of FEELING GOOD and other television efforts in health education. Such a comparison would give a new and useful perspective not only on FEELING GOOD, but on the entire national effort to use television in the service of health education.

Comparisons could be made of such programs and series as the following, which include examples of series and specials on PBS, specials on commercial networks, programs syndicated to commercial stations, and others:

FEELING GOOD (Season A)
FEELING GOOD (Season B)
THE KILLERS
THE THIN EDGE
TODAY'S HEALTH
MEDIX
HOUSE CALL
THE WORLD OF MEDICINE
LIFEWATCH 6
THE TURNED-ON CRISIS
VD BLUES
I AM JOE'S HEART
HOW TO STAY ALIVE
NATIONAL HEALTH TEST

For each program or series chosen for comparison, information should be obtained on the following:

1) amount of programming produced
2) sources and amounts of funding
3) production costs per minute of programming
4) production formats employed
5) size and type of distribution system
6) nature and scale of promotion and outreach activities
7) nature of supplementary utilization efforts and materials
8) audience size and cost per exposure
9) audience characteristics
10) nature of topics treated

11) attitudinal goals and evidence regarding their achievement

12) informational goals and evidence regarding their achievement

13) behavioral goals and evidence regarding their achievement

Although somewhat different dimensions might be required, this kind of comparison could be expanded to include occasional treatment of health topics in daytime serials or in such series as MAUDE, ALL IN THE FAMILY, and GOOD TIMES; brief health features on news programs; public service announcements from various health agencies; and paid commercials such as those used in the Blue Cross "lifestyles" campaign.

Programming for a younger target audience. Although the combination of formative and summative research on FEELING GOOD generated a large evaluation data base, it deals exclusively with adult respondents. However, there are indications that the Season A version of FEELING GOOD may have been (or would be) much more successful with children in the 8-15 age range. Free response data, formative research group discussions, inquiries from junior high schools, and other impressionistic data have generated the unanticipated hypothesis that older children might be a very receptive target audience for the preventive themes of Season A cast in entertaining and short segments.

The importance of this target audience, the indications that the material has good potential for this audience, and the added possibilities of the Season A vehicle (or some future project structured along the lines of the Season A vehicle) being packaged for in-school viewing make evaluation of the programs with younger viewers desirable.

Longer-term assessments of program impact. Most studies of the impact of health education programs or materials are short-term, and thus are unable to provide information concerning the extent to which any observed effects persist over an extended period following exposure. If some of the health knowledge and behavior questions used with the NORC and RAC respondents were to be administered at a later time (e.g., sometime in 1977) to a sub-sample of those respondents, the new data could be combined with findings obtained in the earlier studies to provide comparisons across three time points--November 1974 (pre-series baseline), May 1975 (immediate posttest), and the delayed posttest. Complete data files on all respondents in the earlier studies are still available and could be utilized both in selecting an appropriate sub-sample and in analyzing responses to the follow-up questions.

General Policy Issues and Questions

While the issues discussed in the previous section could be addressed directly with obtainable data, the issues in this section must be dealt with more speculatively. The FEELING GOOD experiment involved a large number of questions dealing with goal-directed uses of television that are not answerable with summative evaluation data or even with a more journalistic-type report of experience with the series. While these issues have been considered by the various departments involved with the series, they must still be regarded as open questions; the FEELING GOOD experience with them is relevant but not definitive.

Combining "messages" and entertainment. One of the difficult tasks facing the series at the outset was to find effective means of drawing the target audience to the programs. In attempting to attract viewers who would not normally watch a health program or a program on PBS, the producers decided initially to use a variety of entertainment techniques and guest stars. One problem was to find an appropriate balance in each program between information and entertainment; another was to combine these two elements effectively within individual segments.

There was an evolution through the series in the direction of making the programs more serious in tone and more straightforward in presenting health information. Although independent measures showed that the later programs were more appealing to viewers, the size of the audience viewing the broadcasts remained about the same, and actually declined as a proportion of those aware of the series. Thus the experience with this series provides somewhat conflicting evidence on the feasibility of adult programming which combines entertainment with material designed to inform or persuade. Perhaps adults, more so than children, expect educative programming to "look" one way and entertainment to "look" a different way. Long exposure to entertainment programs interspersed with commercials may have set up expectations which are difficult to breach with material that combines the functions of both.

The ratio of purposive material to entertainment may be at least as critical a factor as whether these two elements are separated or combined. FEELING GOOD attempted to use essentially all of each program in a purposive way. Producers of future goal-oriented series for adults might consider approximating more closely the pattern of commercial television--that is, separating purposive material from entertainment, and using only a small proportion of each program for "message" content. Systematic evaluation of programs on this pattern would be required to determine whether they could attract a larger audience and how much impact they could have on viewers' knowledge or behavior.

Series versus specials. This issue involves trade-offs which should be assessed empirically. Specials offer several advantages: promotion of single-topic specials can be directed to particular and sharply-defined target audiences; the investment of time in viewing is obviously less for a one-shot special than for a series, so the audience is likely to be larger; production formats can vary from program to program, thus offering greater flexibility to writers and producers. On the other hand, a series also has advantages: repetition can be built in over time, so cumulative impact is possible; there is opportunity to build audience loyalty and identification; a wider range of health topics and goals can be addressed; series momentum can carry an audience through programs that may have less "glamour" or inherent appeal, but which may nevertheless be critical in terms of health education; and the viewer unable to watch a particular program may be reached by programs available at other times.

Scheduling strategy. This issue applies to all television programming. The time of day and the day of the week a program is broadcast, a variable independent of the appeal of the program concept or the quality of the material, can have a significant impact on audience size. The fact that early FEELING GOOD programs fell on Thanksgiving eve, Christmas day, and New Year's Day placed them against special competition on the networks. The series' regular network competition on Wednesday evenings consistently attracted the lion's share of the viewing audience. Theoretical access to the huge number of prime-time viewers must be weighed against the proportion of that audience that can realistically be drawn away from network entertainment. For PBS prime-time programming in general, this proportion was typically very small (about 1-2%), and it was also small for FEELING GOOD. Nielsen ratings indicated that FEELING GOOD attracted about as many viewers in a non-prime-time second broadcast during the week (which varied from station to station) as it did in prime time. At this point, one can only speculate about how much impact a different day or time of broadcast might have had on the audience for the series.

Commercial versus public broadcasting. An earlier chapter reported on the relatively low awareness of public television in general and of specific public television programs; the incomplete geographic coverage of public television; the problems with reception of PBS signals, especially UHF signals; the modest levels of typical viewing (with the notable exception of daytime children's programs); and the higher demographic profile typically associated with the PBS audience.

One of the many intriguing "what if" questions concerns the effects of distribution system on audience size. For example, what if FEELING GOOD had been broadcast on NBC and LITTLE HOUSE ON THE PRAIRIE on PBS? While there is little basis on which to predict specific numbers, it is probably safe to assume that the FEELING GOOD audience would have been many times larger and the LITTLE HOUSE audience many times smaller. Such is the relative power of the two distribution systems, holding programming and scheduling (but not promotion or lead-ins) more or less constant.

However, a number of intervening factors preclude simply recommending commercial network distribution of purposive programs. The issues and barriers are too complex to develop here, but they involve such matters as differential sponsorship and clearances for public and commercial television; the strong desire of the networks to maximize ratings not only of individual programs, but for their schedule as a whole; the very high commercial value of network prime time; legal and philosophical problems in commercial distribution of programming that involves federal funding; and the willingness of public broadcasting to experiment, to invest in goal-directed programming, and to look beyond ratings as a measure of service to the country.

While the barriers are significant, it is not a foregone conclusion that commercial distribution of goal-directed, public service programs such as FEELING GOOD is impossible or unthinkable. Future projects might well consider the pros and cons of distribution systems such as syndicated groupings of local commercial stations. The choice of distribution system, whatever its makeup, should be an integral part of early project planning.

Broadly- versus narrowly-defined target audiences. In specifying a target audience, it is necessary to consider not only the logic of the content but also the demands of the medium. Chapter One summarized how target audiences for FEELING GOOD were defined in terms of age, sex, ethnicity, income, education, parental status, and presence of certain health symptoms or conditions. A strategic media question is: How small can a single target audience be, or how diverse can multiple target audiences be, and still be appropriate for a mass medium such as television?

In commercial television, advertisers for products that have a broadly-based market are in abundance; advertisers for specialty items typically use other media. The issue of universality-specialty applied to FEELING GOOD in that Season A addressed some diverse (and thus relatively small) target audiences, while Season B generally stressed more universal themes. While test audiences preferred Season B, according to several measures, the choice of wider-interest topics was only one of several modifications made in the series.

A related media strategy question involves the extent to which target audience members are more readily available to view (e.g., are already regular viewers of PBS programming), as opposed to the requirement to bring low-probability viewers into the audience through such techniques as community outreach and station promotion. The question was particularly relevant to FEELING GOOD because of its commitment to pay special attention to health needs of the poor and the disadvantaged.

Since the audience for public television is relatively small, it is seen as essential not to lose present viewers in seeking to attract new ones; the task is to add the new audience to the existing audience. This was done with considerable success in the case of SESAME STREET through extensive community outreach efforts, but even then the process took one to two years of intensive activity. Experience again supports the general strategy of choosing goals relevant to a broad audience, and attempting to make the production appealing to diverse groups.

Applicability of the CTW model to FEELING GOOD. A distinctive feature of CTW goal-directed programming has been the "CTW model," which emphasizes cooperative association between production and research staffs. So strong was the commitment to the CTW model in the case of SESAME STREET that a condition for hiring creative staff was their willingness to go beyond the task of producing quality programming to acceptance of the requirement that this programming must be goal-oriented. It is this added dimension of responsibility for effects that generates the need for cooperation between production and research staffs. This criterion does not apply to most television programming; that is, measures generally deal with whether the desired number of people watched a program, and not with what they did as a consequence of watching.

The elements of the model used with SESAME STREET were also present in the case of FEELING GOOD: content task forces, specified goals, an in-house formative research staff, a National Advisory Committee, a Research Advisory Committee, externally-contracted summative evaluations, and so forth. However, one organizational feature of FEELING GOOD made it more difficult than with previous CTW series for these elements to interrelate smoothly. The funding for the series as a whole was not secured at the beginning of the project, but accrued through three distinct phases, with termination possible at the end of each one. One consequence of this phased funding process was the inability to have continuity in the production staff throughout the term of the project. This made it more difficult to establish close working relationships between producers and researchers and to give complete information to new producers on previous formative testing of program materials. Presumably the CTW model of producer-researcher team effort would have been implemented more effectively under conditions of staff continuity.

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Experimental versus service delivery functions. Aside from the goal of being a "hit" in television terms, FEELING GOOD had two major purposes: it sought to provide effective health education (the service delivery function) and to produce knowledge about health communications (the experimental function). These are not necessarily opposing functions; in a project which continues for several production seasons, they are obviously complementary. However, the relative amount of emphasis on the two functions is an important policy issue.

For example, an increased experimental emphasis in combination with less emphasis on service delivery would perhaps have generated a greater variety and number of planned variations in production formats, influence strategies, utilization activities, and so forth. Each program could have been similar to a pilot, and the effects measures would have been restricted to those applicable to such short-term exposures. The cost would be a more limited pool of evidence; the gain would be some experience with more programming options. Another trade-off might be greater experimental control under less feasible or realistic conditions of broadcasting.

Conversely, a better "batting average" on impact measures could have been achieved by emphasizing the service delivery function and de-emphasizing the experimental aspect. This would imply selecting only conservative goals (those with a high probability of success), and treating them extensively with techniques already known to be effective. The trade-off here is a higher probability of success in a smaller number of goal areas, with minimum opportunity to learn something new as a consequence.

A natural desire is to exercise both functions to their fullest extent, but available funds typically will not permit this, and some compromises are nearly always required.

In the case of FEELING GOOD, the greatest opportunity to explore a variety of very different production formats came in Phase II, with the formative testing of various segments in a one-hour sample reel. Once the commitment had been made to the Season A vehicle, and to its service delivery goals, it was then harder to introduce new experimental variations that went beyond the scope of that concept.

Limited data were collected on a greater variety of approaches in the sample reel segments, while more extensive data were collected on the smaller number of variations in the programs for Seasons A and B. This illustrates the nature of the trade-offs in the FEELING GOOD experience, but this experience alone cannot answer the policy question of the optimum balance between the experimental and service delivery functions.

During its period on the air, FEELING GOOD was only a small part of the nation's total health education effort. The health problems which motivated the production of the series remain, and attempts to reduce them through education will continue on a large scale. Thus the primary contribution of the evaluation report is not as history, but in its implications for future policy and practice. This perspective has been used in analyzing and reporting the evaluation of this experimental series in the hope that the findings regarding program impact, and descriptive data on various health beliefs and behaviors, and the methodological details presented will be useful in the planning and evaluation of future efforts of this kind.

APPENDICES

A. Sources of Funding

B. National Advisory Council

C. Research Advisory Committee

D. Task Forces

E. FEELING GOOD Staff

F. Children's Television Workshop Staff

G. "FEELING GOOD: The Anatomy of a Program"

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Exxon Corporation

Aetna Life & Casualty Company

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American Heart Association

The Edna McDonnell Clark Foundation

Robert Sterling Clark Foundation

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Director of Content Development: Ruby P. Hearn, Ph.D.

Co-Executive Producer: Robert Bendick (Season B only)

Senior Producer: Al Morgan (Season A only)

Show Producers: (Season A) Robert Cunniff, Art Holch

(Season B) Charles Andrews, Mary B. Brown, Craig Fisher, Art Holch, Don Mischer, Sheila Nevins, Ernest Pendrell, Lou Solomon, Al Waller

Segment Producers: Peter Altschuler, Penny Bernstein, Marc Brugnoni, Nell Cox, Shirley Dallard, Ron Finley, William Greaves, Frank Morrero, Susan and Alan Raymond, Beverly Schanzer, Shirley Wershba, Edith Zornow

Variety Producer: Martin Leshner

Assistant Variety Producer: Sylvia Pancotti

Associate Producers: Shellee Lipton, Nola Safro

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Associate Directors: Merrily Mossman, Stan Spiro, John Tracy

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Writers: Cynthia Adler, Carol and David Axelrod, Herb Hartig, Jan Hartman, Yvette Hawkins, Harvey Jacobs, Peter Kassan, Romulus Linney, Tom Meehan, Ernest Pendrell, Christopher Porterfield, A. J. Russell

Music Director: Stephen Lawrence

Music Coordinator: Danny Epstein

Song Writers: Martin Charnin, Bob Kessler, Stephen Lawrence, Stephen Schwartz, Bill Withers

Lyricists: Gretchen Cryer, Tony Geiss, Herbert Hartig, Ed Kleban

Sketch Coordinator and Choreographer: Neal Kenyon

Scenic Designer: Frank Lopez

Costumer: Ramsey Mostoller

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Duncan Kenworthy, Betty Rothenberg,
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Operations Manager: Robert Dahl

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Albert H. Dwyer
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APPENDIX G

"FEELING GOOD: The Anatomy of a Program," by William Kobin. Reprinted from Public Telecommunications Review, Vol. 4, No. 1, January/February 1976, pp. 32-37.

(This article is adapted from a presentation given to a research session at the 1975 annual convention of the National Association of Educational Broadcasters.)

PRODUCER'S NOTEBOOK

William Kobin

FEELING GOOD: THE ANATOMY OF A PROGRAM

"Feeling Good," CTW's adult health series, went from the drawing board to the screen—back to the drawing board and on the air again. Here is the story behind "one of television's more ambitious experiments".

"Feeling Good," produced by the Children's Television Workshop for PBS, was television's first sustained attempt to provide a national audience with health information in an entertainment format and to motivate them to change their health habits.

Originally planned as 26 one-hour programs, the series was later modified to consist of 11 one-hour programs and 13 half-hour programs. The hour-long version was broadcast from November 20, 1974 to January 29, 1975. The half-hour series ran from April 2, 1975 to June 25, 1975 and was repeated by PBS from July through September.

In this Producer's Notebook, *the Project Director of "Feeling Good" talks about the goals, problems, and decisions of this unusual series.*

One of television's more ambitious experiments was the Children's Television Workshop's adult health series, "Feeling Good."

Studies to assess the impact of the series are not yet complete so it is too soon to know its effects on viewers. But there is much in the history of the project that I think will be of interest to broadcasters and health educators alike.

It is my hope that everyone who shares an interest in learning from the "Feeling Good" experience will have as clear an understanding as possible of what we wanted to do and why we did things the way we did.

This then, is a look at the evolution and development of "Feeling Good"—our objectives, some of the problems we encountered, and the rationale for our decisions in trying to solve them.

CTW's decision to undertake this project grew out of the belief that the research/production model which evolved "Sesame Street" and "Electric Company" for children could be used—with modifications—to develop TV programming for adults.

Health was chosen as the subject area primarily because it is relevant to every American and because it presents enormous problems and questions for almost all of us.

Initially, funding was obtained for a feasibility study only, and the project was designed to develop in 3 phases: phases II and III dependent on the successful conclusion of phases I and II respectively, and the funding of the total project uncertain though likely at the outset.

This proved to be a major liability, since production personnel were not on the project from the beginning and none of them had the benefit of that continuity.

It also meant that there were gaps between the phases while we engaged in fund-raising activities and waited for go-ahead commitments to be made.

Phase I

Phase I involved a feasibility study undertaken during the second half of 1972 and culminating in the writing of a comprehensive proposal.

A small group of 5 worked together closely in interviewing some 170 health professionals throughout the country. That group included a representative of the CTW Research Department, the person who later became Director of Content Development, an interviewer/writer, the assistant project director, and myself. We worked closely during that period with Dr. Edward Palmer, the CTW Vice President for Research.

While the "Sesame Street" and "Electric Company" experiences were relevant, it was clear that there were also major differences between them and the health project. We were, for example, planning a prime-time series for adults. That audience could not be brought to the TV set, it would have to be attracted. And it was not necessarily motivated to learn about the subject matter as most child viewers of "Sesame Street" are to

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William Kobin is Vice-President of the Future Works Division of the Children's Television Workshop, and served as the Project Director and an Executive Producer of "Feeling Good." This article is adapted from a presentation given to a research session at the NAEB 51st Annual Convention in November, 1975.

learn about the curriculum of that series. Furthermore, the health subject matter was much more complex than that of the children's series.

During this feasibility study we were primarily interested in determining:

- whom the series should be aimed at?
- what topics should it cover?
- what should the TV format be?
- how might the formative and summative evaluation be developed?
- how might we influence health behavior?
- how might the reach of the series be extended through outreach and promotion?

From the outset we considered the entire project an experiment and opted to take the maximum number of chances and to do everything the hardest possible way.

First, we wanted to reach a wide diversity of target audiences. We were particularly interested in reaching poor people because health problems are especially severe among them and access to care is frequently the most difficult for them. We felt an obligation to try to attract them to the series despite the fact that the poor are not, for the most part, viewers of public television. At the same time we wanted to appeal to public television's middle class audience because it is impossible for a major series to survive on PBS without the support of that audience. So we took on the difficult challenge of trying to develop a series which would appeal to a great diversity of audiences simultaneously.

We determined that the overall aim of the series should be to try to get people to think about what they can do to improve their own level of health and that of their family. The basic theme, we decided, should be that health is closely related to lifestyle and that most individuals have greater responsibility for and control over their health and that of their family than they realize.

We also decided to put the emphasis on prevention rather than cure, on helping people stay well rather than get well. Even though this would be the least dramatic approach to the subject matter, there was overwhelming consensus that this was the most valuable service we could perform.

Thus, during Phase I, we developed a list of some 70 topic possibilities the series might cover. This list would have to be narrowed down in Phase II—assuming there would be a Phase II—but quite clearly the series was going to deal with a wide range of subject matter, some of it very complex. Later, we decided to focus on many health problems which are especially prevalent among the poor even though they have little relevance for the more affluent, better educated target audience. We also selected some health problems because of their high incidence even though they are not of high interest (for example, dental care, nutrition, need for vision and hearing screenings, hypertension).

Another tough challenge was to produce a series which would influence behavior. We were particularly interested in motivating people to change their health habits in measurable ways. We wanted to go beyond mere presentation of information. This would influence our thinking about the show's format and content since, clearly, the presentation of information, alone, does not necessarily motivate people to act.

We had no illusions about the enormous difficulty involved in getting someone to change his or her health behavior, and we knew that mass health education efforts in the past had usually met with scant success. We also knew that ours might not measure up to everyone's expectations. But we knew we'd never find out if we didn't try. So we decided to try and to make our effort different from—and we hoped better than—anything that had preceded it.

From the beginning, we rejected all conventional public affairs approaches. We were committed to experimenting with an innovative format that would combine the widest diversity of television techniques ranging from serious information to frivolous entertainment. Nothing in the project was more experimental than the attempt to blend songs, sketches, documentaries, straight talk, animation and other television forms into a cohesive, hour-long program. From the outset, the key question in this regard was just what the ratio of light to serious material should be and how this mixture of formats could be made to work.

We wanted to develop a new format for a number of reasons:

First, preventive health is ignored by many, if not most, people. We wanted to attract some of those unmotivated people.

Second, we wanted to attract some of the viewers who watch commercial television and who watch it primarily for entertainment. Since we were going to be opposite prime-time commercial programming, we felt our series should be attractive as pure entertainment as well as be educational. We even hoped some people would watch it for sheer entertainment regardless of their interest in health.

Furthermore, there had never been a continuing television series—although there had been 1-shot specials based on crisis topics—which attempted, through entertainment, to reach a mass television audience with basic preventive health information. We felt that approach should be tried.

In essence, we wanted to use mass entertainment TV techniques and guest stars to reach a wider audience. It had worked for "Sesame Street" but the problem is clearly much greater when trying to reach adults and when dealing with more complex subject matter.

Finally, the project was a television experiment as well as one in health education, and we wanted to break away from the conventional uses of the medium and try new approaches and combinations.

During Phase I, preliminary plans were made for the selection of topic goals and objectives for the series, the formative research which would test programming and feed the results of that testing back to producers, and the summative evaluation which would determine the effectiveness of the series.

Outreach also was a key concern. The CTW Community Education Services Division (CES) began making plans to work with a wide range of national and local organizations on state and local efforts to extend the reach of the series to more poor people and minority groups. We also hoped to get every PBS station to work with local health agencies on community health activities.

Measuring audience response was a key element in the development of "Feeling Good." Here, in one of the many test sessions during the two-year pre-broadcast period, audience reaction to a sample show segment is studied.

Clearly, we were thinking of much more than a television series. We were projecting the development, execution and evaluation of a major experiment in health education. We wanted everything: nothing less than effective health education and a prime-time entertainment hit.

Phase II

When we received the go-ahead for Phase II—approximately 2 months after the completion of Phase I—we held a series of seminars with health professionals from around the country to begin to boil down our list of topic possibilities. These meetings were planned and conducted with our research and content development people with whom we then worked to develop a long, preliminary list of educational goals for the series.

From this list we designated a number of top priority goals for experimental program segments to be produced and tested later in the year.

(At the same time we were testing audience reaction to existing health films and programs; attempting to identify the health needs of various target audiences; and continuing to plan the formative and summative research, PBS station involvement, and CES projects.)

In developing the test program segments, we began to grapple with the problem of program format. We assembled a small, short-term production staff and commissioned several sketches, short plays, songs, documentaries and what we called "health commercials." All were based on specific goals and objectives devised with our research and content development people and reviewed by outside advisors.

We formed a resident company of actors and actresses to serve as collective hosts and performers in these segments. We wanted to avoid the conventional use of a host or hostess and hoped to devise an innovative way of bridging the various segments. We wanted our resident company to be racially mixed, hoping that would have the greatest credibility and appeal to our target audiences.

Initially, we considered using something of a variety show magazine format for the series. We wanted to produce a multi-segmented, hour-long format using a wide range of light and serious techniques. As I've said, the extraordinarily difficult question was what the best balance of light and serious material should be to have maximum impact on the audience. And how, not simply to present information, but how to influence viewers to take such specific actions as getting a blood pressure check, having a Pap test, having their children immunized, and so on.

We also wanted to treat several topics during each program rather than deal with one topic for an entire show and never return to it. We hoped, thereby, to attract and hold viewers who might be interested in at least one of each show's topics though not necessarily all of them.

We also hoped that repetition both within a single program and over the course of the series would have a cumulative effect on the audience.

We produced two hours of sample segments and tested them for appeal, credibility, and potential for conveying information. In testing them, we surprised production people with these results:

1. The very high appeal of the documentary segment (in addition to its success in conveying information.)

2. The degree to which test viewers felt the comedy material was childish or sugar-coated or condescending (which obviously was not our intention.)

3. The almost unanimous dislike of Bob and Ray who had taped two segments for us.

It was quite clear from the findings that we would have to increase the amount of serious material in our next round of production.

At this point the production unit, with the exception of the head writer, was disbanded. A couple of months of report writing and fund-raising efforts followed and, toward the end of the year, we held two additional seminars and identified the prospective members of our National Advisory Council and Research Advisory Committee.

Phase III

Early in 1974, Phase III began. New production personnel were brought in to further refine the show concept and develop a pilot program. The search for that staff was extremely difficult. The highly diversified nature of the formats required people with a wide range of different television experiences. Ideally we needed someone who had produced "CBS Reports," "Sanford & Son," "The Flip Wilson Show" and "Playhouse 90." Unfortunately, there isn't any such person. We also needed bright, committed, content-oriented people with a feeling for and knowledge of show business. We wanted people who were sufficiently disciplined to work with Content Development and Research.

In designing the pilot show, we decided to stick with the basic idea of a resident company but planned to create a cast of characters with well developed and differing personalities (unlike the depersonalized, musical review-like cast of our test material) and to locate the company in a realistic place rather than the abstract television studio we had used for the test segments.

We wanted to set our characters in the kind of place where the paths of many different kinds of people might really cross and where some of them might logically have an opportunity to develop close relationships. Airports, train stations and bus stations were out because they're crowded and most people are simply passing through them. An apartment house didn't seem appropriate because we didn't think the variety of characters we wanted really would live in the same apartment house. Finally, we decided on a small store in a shopping center which would be adjacent to a range of differing neighborhoods. We settled on a small variety store with a food counter where people could sit and talk. We called it "Mac's Place."

We decided to make all the sketches and settings more realistic than we had in most of the test segments, and to use more live-action film and real people. We were moving away from a variety show format and closer to situation comedy with film and tape features and songs. (Testing, incidentally, indicated that songs could be quite effective if they were not explicitly health concerned, exhortative or packed with information.) We also planned to use at least one strong, human documentary each show.

Again, as with the test material, each segment was based on goals and information developed by Research and Content Development. All scripts were discussed in meetings involving research, production and content development people. Those meetings were sometimes heated and frequently left no one completely satisfied. It was particularly difficult to reconcile problems in the area of comedy. These might include differences over how much and which information should or shouldn't be included in a segment, the effect of the informational content on the humor in a segment, what might make a segment boomerang, the effect of ridicule and satire, the use of negative models, and so on. We had some great debates and frequently people had to make compromises.

Testing the Pilot

Testing of the pilot material completed in July provided some significant insights: for one thing, it gave a reading on the appeal of the characters in the "Mac's Place" segments. One of them—the old lady—proved to have an unexpectedly high appeal as a representative of the elderly; another annoyed a segment of the Spanish-speaking target audience, which was not totally unexpected. There were also early indications that the appeal of "Mac's Place" varied with the education and income of target audiences; that satire and parody were very risky; that songs could pack tremendous emotional wallop if they were used properly; that the bridges we had carefully constructed in and out of the Mac's Place

Originally, "Feeling Good" was scheduled as 26 one-hour programs set in Mac's Place, a small variety store that served as a meeting place for the cast of characters.

segments frequently didn't work; that short documentaries continued to have high appeal and convey information in the overall format; and that we still had a problem finding the right ratio of light and serious material since many test viewers continued to want more serious content and more information. Overall, however, the pilot tested well; considerably better than early shows in the series would test later.

Meanwhile, there was considerable staff turnover and several new producers and writers were brought in.

Pre-production planning began almost immediately with little chance for the new people to absorb the background of the project, or for production people to study incoming results of the pilot testing.

The results of the pilot testing, coupled with later tests of show #1 and our own instincts, convinced us to make Mac's Place segments more serious and to give the characters more depth. (Subsequently, we decided to try some straight stand-up information pieces which were introduced into the series in program #2 with surprising success).

Although far from completely satisfied, we maintained the production schedule and made modifications along the way. The staff was faced with a tremendous production load and very tight deadlines, as we raced toward a November 20 premiere.

The critical reaction to the premiere was, for the most part, quite good. Of 50 reviews from around the country, 34 were highly favorable, 5 were mixed to good, and 11 were bad. One of the 11 was the prestigious *N.Y. Times*.

The national Nielsen AA rating for the premiere was 2.8. This is high compared to most PBS prime-time ratings but it was disappointing to some who expected, unrealistically, I believe, 5's and 6's like "Sesame Street" receives. Ultimately, the Nielsens leveled out to a national AA rating average of 1.4 for the hour-long series, placing "Feeling Good" among the higher rated PBS prime-time series of the season.

But, we were not reaching the numbers of viewers we wanted to reach; nor did we appear to have the kind of support we wanted from the PTV audience. Furthermore, we, ourselves, weren't satisfied with the format and during production of the first few shows, we developed increasingly strong feelings—most of which seemed to be borne out by formative testing—about how to strengthen the series. So early on, we began to modify the format in several ways:

First, we began to make the "Mac's Place" segments more serious and to reduce the amount of show time devoted to them. Eventually, we decided to cut back on this area of the show further and considered eliminating "Mac's" completely in some shows.

Second, we felt the show should be still more serious and contain more hard information.

We also wanted to make individual segments longer and fewer topics each show, making the program more cohesive and to lighten the production load.

As we contemplated those major modifications, it became clear that we were confronted with a choice: either make the changes while the series was on the air, or take it off altogether and take a little time to think over and implement the restructuring.

We decided on the latter course. I think it was a bold decision, based on the belief *not* that the series was a failure, but that we could do a still better job. We thought that the experimental nature of the project provided this justification and the freedom of public television gave us the flexibility for such a move.

It was, therefore, surprising and ironic to us that the withdrawal was interpreted by many as an admission of defeat.

During that hiatus (which, incidentally, was very short—we were off the air only two months) we decided on several basic format changes: cutting the show to a half-hour; substituting Dick Cavett for "Mac's Place"; devoting each show to a single topic; focusing on emotional topics of broad interest; and finally, making the shows more serious and informational to increase appeal for the PTV audience, hopefully without losing the larger potential audience of non-PTV viewers.

In making these changes, we were not departing very much from the overall content and approach of the series, but we were changing the form of our presentation.

When we came back on the air, the critics' reaction to the half-hour series was overwhelmingly favorable. The revised 13-week series ran from April through June and was repeated by PBS during the summer. Evaluation studies on the impact of both the hour-long and half-hour series are now being completed.

The summative evaluation of "Feeling Good" is probably the most extensive ever carried out on a television series in health education. It involves major studies by the Response Analysis Corporation, the National Opinion Research Center, the Gallup Organization, and the A.C. Nielsen Company. These national and local studies deal with the effects of programming on attitudes, knowledge and behavior; the size and characteristics of the audience; and program appeal. The summary report will be finished in the late winter or early spring of 1976.

One major aspect of the project has not received the attention it deserves. That is its extraordinarily impressive outreach activity. If projects like "Feeling Good" are to be most effective, they must have extensive support like that provided us by CTW's Community Education Services Division (CES) and the PBS stations.

CES staff engaged in a tremendous two year effort. They contacted over 1500 health organizations throughout the country and alerted an estimated 3½ million people—mostly in poor and minority communities—with flyers, newsletters, radio appearances, etc.

They also organized more than 75 special community projects—such as health fairs and screening drives—in hospitals, schools, clinics, colleges, even Indian reservations.

The PBS stations also gave us terrific support. Eighty percent of them inserted local referral slides into the shows which listed names, addresses and phone numbers of local health agencies.

The response to referrals, incidentally, was most heartening. The American Dental Association re-

FEELING
GOOD

The re-designed "Feeling Good" was a series of half-hour programs with more serious formats, hosted by Dick Cavett.

ceived 6000 requests for free disclosing tablets; the American Hospital Association, 2800 requests for the Patients Bill of Rights. We received some 40,000 requests for our Smoker's Quitter's Kit. In New York City alone, the American Cancer Society received over 5000 inquiries during the series.

Eight key stations* engaged in a wide range of special outreach projects under a grant to CTW from the National Institute of Alcohol Abuse and Alcoholism which was administered by the project. Those stations report that they have: 1) stimulated their communities to do a lot more in the areas of preventive care; 2) made contact with many local health agencies and brought them together for the first time; and 3) greatly increased their own visibility as organizations interested in outreach generally and health specifically.

Without question, outreach and promotion are critical in a project like "Feeling Good". I hope others will attempt similar projects in the future and that they will recognize the importance of these activities. If I'm involved in this kind of project again, I'll try to devote a considerably larger percentage of the overall budget to these areas.

I think there is a great deal to be learned from this project, both for those specifically interested in health education and, more generally, for those interested in using television for adult education.

The project sheds light on questions which I hope will be pondered by future planners, questions relating to:

- the use of entertainment in educational programming for adults
- the uses of public television
- problems of reaching diverse audiences simultaneoulsy
- the importance of outreach and advertising
- the determination of realistic expectations and criteria for evaluating success or failure
- and many others

This has been an immensely complicated project and one which perhaps has not been made clear to everyone. I hope these observations help to increase the understanding of "Feeling Good."

• • •

**WJCT-TV, Jacksonville, Fla.; KCTS-TV, Seattle; WCET-TV, Cincinnati; WMAA-TV, Jackson, Miss.; WPSX-TV, University Park, Pa.; WNED-TV, Buffalo, N.Y.; KQED-TV, San Francisco; and the Maine Public Broadcasting Network.*